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The Recognition of Faulty Posture

By Lloyd T. Brown, M.D.

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Happy New Year

THE New Year is the time when we try to get outside ourselves and take a detached view of ourselves and our work. How will it all look to us ten years from now? How do the things we were doing ten years ago, which seemed very important then, appear to us now? Have we learned something of life in the last ten years which will help us to do our work more sanely and simply in the next ten years?

Looking back we see certain broad accomplishments and failures. The rest is a blur of details, none of them of much consequence in themselves; some of them contributions to progress, many of them false starts, not a few of them steps backward. But taken all in all we discern a general movement forward.

We regard, with a certain amusement, the importance we attached to small difficulties in our path and the serious consequences we anticipated as a result of our frequent failures to carry our plans through. From the vantage point of years we can now see that many of those failures and delays were really for the best. The time may not have been ripe—perhaps we had not done enough breaking of the ground, or created a wide and genuine public sentiment. Or perhaps we had not thought our idea through with sufficient clearness. It may even be that sometimes our idea was quite wrong. Possibly we may be thankful today that some of our too hasty schemes *did* miscarry.

Meditating thus on past performances, I seem to discern two or three lessons rather clearly. Is it not often true that we undertake too many things at one time? That half truth "Never put off till tomorrow what you can do today," seems to stimulate our conscience more than our common sense and leads us to think that we can and must do today more than we really can do well. Another mistake we often make is to expect immediate results. We are slow in learning that to accomplish even a

small advance often takes a number of years and that frequently an obstacle must be attacked many times and in many ways before it is finally removed. And do we not sometimes take upon ourselves too much responsibility for results?

"Trust in the Lord and do good," says the psalmist. "He that believeth shall not make haste," declares Isaiah.

Can we not devote ourselves to doing the best we know and cease to fret unduly over the results? Can we not free ourselves from the pressure of trying to redeem the world in our own lifetime and allow things time to ripen naturally? Forced cultivation and artificial stimulation do not breed strength and vitality. Can we not get more of a perspective on life, its intricacies, its profundities and its slow evolution?

One way to gain a partial perspective is to meet with nurses of many nationalities and to learn of the development of nursing in many lands. The meeting of the International Congress of Nurses in Helsingfors in July gives us this opportunity and it is expected that a goodly number of American nurses will attend. Knowing something of the quality of mind and spirit of our sister nurses abroad and of the excellency of their work, may I be forgiven for saying it is not without some qualms that I contemplate the invasion into Finland of some hundreds of ardent American nurses. Without depreciating the very considerable sum of the achievements of nursing in America, may we not surprise our sisters of the old world by our moderation and humility and our genuine desire to learn. And may we bring home with us a clearer perception of the meaning of our work and of its proper place and importance in the march of world affairs.

ELIZABETH GORDON FOX.

We call attention to the article in this number on "The Children's Amendment" by E. N. Matthews of the Children's Bureau. Public health nurses are vitally concerned with all the questions which enter into the consideration of child labor as a whole. We know all desire to become thoroughly informed as to the pros and cons of any measure regulating it. We hope Miss Matthews' article will help each one of us to arrive at a wise decision about this particular measure.

We also call attention to a *Survey of Minnesota County Nursing Services.* The impartial manner in which the report of this survey is given will, we believe, be helpful and encouraging to other groups estimating their shortcomings as well as their successes.

As only 200 nurses have signified their interest in the trip to Helsingfors to date, it will not be possible as hoped to charter a steamer sailing directly to Finland. Reservations have been made on the *Caronia,* of the Cunard Line, sailing from New York June 8, 1925. The *Caronia* is a 20,000 ton ship and makes the crossing to Liverpool in about 7½ days. The trip across England and the North Sea will be made as comfortable as possible.

The fare one way from New York to Helsingfors, including all meals and sleeping accommodations, will be approximately $175.00, plus $5.00 U. S. Government tax. An extra $10.00 will assure better quarters on the *Caronia.*

Thomas Cook & Son are coöperating with the Cunard Company and are preparing a booklet suggesting suitable tours of varying duration, as it is believed that most of those attending the Congress from the United States will wish to avail themselves of the opportunity to visit other European countries than Finland.

It is estimated that the total expense of the round trip, including accommodation and meals in Helsingfors, will be about $420.00, but this of course would not cover a tour to any other country.

THE CHILDREN'S AMENDMENT

By E. N. Matthews

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ON September 1, 1916, with the signing of an Act of Congress which closed the channels of interstate and foreign commerce to the products of establishments employing children contrary to the provisions of the Act, it was believed that the ten-year struggle for federal regulation of child labor had come to an end. But the passage of this, the first federal child labor law, proved to be merely a signal for reopening the struggle on new ground. No longer was the chief question at issue "Shall federal legislation be resorted to?" but "Does Congress have power to legislate on the subject?" That the power to protect the children of the nation from industrial exploitation does *not* reside in the Congress of the United States has since been twice indicated by the U. S. Supreme Court—first, on June 3, 1918, when it declared the first federal child labor law null and void on the ground that it was not a lawful exercise of the power of Congress to regulate interstate and foreign commerce, and again on May 15, 1922, when it handed down an adverse decision in regard to the Federal Child Labor Tax Act of 1919, which had sought to discourage child labor by imposing a tax of 10 per cent on the net profits of establishments violating standards set up in the Act.

To-day, more than eight years after the first attempt of Congress to deal with the problem through existing powers, the question before the country is "Shall Congress through an amendment to the Federal Constitution be given specific power to legislate against child labor?" Such an amendment, passed by both the Senate and the House of Representatives by more than the requisite two-thirds vote, is now before the states for ratification.

Whether the state legislatures accept or reject the proposed amendment depends to a very large extent upon how well understood are:

(1) The facts in regard to child labor and its present regulation and

(2) The nature and scope of the powers that the amendment proposes to confer on Congress.

The Situation To-day

Over one million children from ten to fifteen years of age, inclusive, one child in every twelve of those ages in the entire country, were reported in the 1920 census as gainfully employed. The number does not include children merely helping their parents at household tasks or chores, or doing irregular work about the home farm—the census enumerators were instructed not to count such children as "employed." Nor does it include children employed only during the summer vacation, or in seasonal work either on farms or elsewhere, for the census was taken in January when little or no seasonal or farm work is in progress. The census year, moreover, fell during the period when the Federal Child Labor Tax Law was in operation and was discouraging the employment of many children between fourteen and sixteen as well as under fourteen.

Hundreds of thousands of children were employed in non-agricultural occupations. For example, cotton mills, woolen and worsted mills, and silk mills employed 38,975 child operatives; iron and steel mills employed 12,904; clothing factories and sweat shops, 11,757; lumber mills and furniture factories, 10,585; shoe factories, 7,545; coal mines, 5,850. There were 41,586 child servants and waiters, 48,028 messengers, bundle wrappers, and office boys and girls; 30,370 sales boys and sales girls in stores, and 22,521 child "clerks" besides those in stores. Although it is generally conceded that children under fourteen should not be put to work in mills, factories, and workshops, approximately 10,000 from ten to thirteen years of age, inclusive, were employed in manufacturing and mechanical industries.

In considering how seriously the childhood of the nation is affected, it is

important to remember not only the thousands of children at work at any given time but also the thousands who are constantly replacing them; thus, if 400,000 children, fourteen and fifteen years old, are employed to-day in our factories, workshops and stores and in other non-agricultural work, in two years from now 400,000 others will have taken their places. While legislative bodies debate, the number of child laborers, with their opportunity to grow and play and learn like more fortunate children gone forever, reaches into the millions.

More than two and a half years have passed since the Child Labor Tax Law was declared unconstitutional, yet the states have shown little disposition to supply through legislation of their own the safeguards which the federal law had given or to advance in other ways the standards of their child labor laws. Since May, 1922, the legislature of every state has held at least one regular session, but, although some advances were made, not one of the thirty-five states whose child labor standards were below those of the former federal laws brought its laws up to those standards in every particular. During the last two years many state legislatures have been not merely negative in their attitude toward child labor, but have defeated attempts to improve conditions of child labor. Only thirteen state child labor laws now measure up without exemptions to the standards set by the former federal enactments and only eighteen are substantially in accord with these standards.

State Laws Inadequate

Eleven states allow children under sixteen to work nine, ten, or eleven hours a day, and one has no regulation of the daily hours of work for children; four states permit children under sixteen to work at night. Taking the country as a whole the laws do not adequately protect children under eighteen, or even under sixteen, from hazardous and injurious occupations.

These are the facts as to child labor and its present regulation. As for the nature and scope of the grant of power, the proposed amendment reads as follows:

> Section 1. The Congress shall have power to limit, regulate, and prohibit the labor of persons under eighteen years of age.
>
> Sec. 2. The power of the several states is unimpaired by this article except that the operation of state laws shall be suspended to the extent necessary to give effect to legislation enacted by the Congress.

The amendment is a grant of power, not a law. It merely confers upon Congress the power to make such laws limiting, regulating and prohibiting the labor of persons under eighteen years of age as public opinion may from time to time demand. As section 2 indicates, it does not take away from the states the right which they now possess to limit, regulate, or prohibit the work of minors. It proposes only the enactment of a federal minimum standard and in no way restricts the right of any state to go outside or beyond the minimum. Experience in administering the former federal child labor laws has shown that such a federal minimum standard stimulates state responsibility, reinforces public respect for state laws, and makes possible national, state, and local coöperation in safeguarding the young worker.

Why 18 Years Was Chosen As Age Limit

A definite age limitation upon the power of Congress had to be specified because the word "child" has been so variously interpreted in law as to make it very uncertain, if it had been used in the amendment, just what power Congress actually possessed. And eighteen years was chosen as the upper age limit because the amendment contemplates regulation as well as prohibition. Many of the states have found it necessary to regulate the employment of boys and girls between fourteen and eighteen, and even up to the age of twenty-one, in occupations which are extra hazardous physically or morally, or to protect them from employment for too long hours or at night. In this

connection it may be noted that of all the children under sixteen reported in the census of 1920 as engaged in manufacturing and mechanical industries, one-third were working in states where the state child labor laws then permitted and still permit a working day of nine, ten, or eleven hours, or even longer. It is also worthy of note that, according to recent studies of industrial accidents to minors, sixteen- and seventeen-year-old boys and girls suffer proportionately more accidents, and more serious ones, from power-working machinery (the source of greatest accident hazard to young workers) than do children under sixteen, who are more adequately protected by law from hazardous occupations, or than young workers between eighteen and twenty-one, who are better able to protect themselves. The right of these older boys and girls to protection from overlong hours, from work at night, and from occupations in which they are likely to be killed or permanently disabled is as fundamental as the right of the child under fourteen to freedom from the burdens and penalties of wage-earning.

Although the amendment contemplates limitations and regulations upon the work of minors up to the age of eighteen, such as the various states now have the power to exercise and do exercise, it does not contemplate a law prohibiting persons under eighteen from working. No such law has ever been passed by any of the states, though each and every one of them now has more extensive powers in respect to the employment of minors than would be granted to Congress under the proposed amendment. Congress, like the states, is limited to acts which are within reason and which would be sustained by the courts as reasonable.

Congress Will Not Control Education

Neither does the amendment give Congress control over the education and training of young persons under eighteen. Dean Roscoe Pound of the Harvard Law School, commenting on this point, says:

> The amendment says nothing whatever about education. What it says is that Congress may regulate and prohibit child labor. Under the tenth amendment, "the powers not delegated to the United States by the Constitution nor prohibited by it to the states are reserved to the states respectively or to the people." This seems to me to settle the matter. There being nothing whatever in the Constitution about education, it is committed to the states respectively where it stands now.

Undoubtedly the Supreme Court would hold unconstitutional any attempt of Congress to control state educational systems through the powers in respect to labor granted under the amendment just as in other instances it has held that Congress may not under cover of executing its powers pass a law for the accomplishment of an object lying outside such powers.

The three chief presidential candidates in the last election endorsed the amendment. The American Federation of Labor, the Federal Council of Churches and the following twenty-one national organizations urge its ratification:

> American Association of University Women; American Federation of Teachers; American Home Economics Association; American Nurses' Association; General Federation of Women's Clubs; Girls' Friendly Society in America; Ladies of the Maccabees; Medical Women's National Association; National Child Labor Committee; National Consumers' League; National Council of Catholic Women; National Council of Jewish Women; National Council of Women; National Congress of Parents and Teachers; National Education Association; National Federation of Business and Professional Women's Clubs; National League of Women Voters; National Woman's Christian Temperance Union; National Women's Trade Union League; Service Star Legion; Young Women's Christian Association.

The Association of State Labor Officials has three times endorsed the principle of federal regulation of child labor. The principal opponents to the amendment at the time of the hearings held before the House Judiciary Committee were:

> The National Manufacturers' Association; the Pennsylvania Manufacturers'

Association; the Southern Textile Bulletin; the Sentinels of the Republic; the Moderation League of Pennsylvania; the Women's Constitutional League of Maryland (an organization with fifty active members formed to oppose the maternity and infancy act); and the Woman Patriot Publishing Co., first established as the organ of the Antisuffrage Association.

Since that time the National Committee for Rejection of the Twentieth Amendment, which is composed of manufacturers, has been formed. One state, Arkansas, has ratified the amendment; one, Massachusetts, submitted it to a referendum, which rejected it, but as the referendum was advisory and not mandatory final action lies with the state legislature. Three states—Georgia, Louisiana and North Carolina—have rejected it. The question will presently come before thirty-eight state legislatures meeting in January. Thirty-five states are needed to complete ratification.

PROGRESSIVE STEP TAKEN BY THE U. S. VETERANS' BUREAU TO IMPROVE ITS NURSING SERVICE

The Director of the U. S. Veterans' Bureau has approved the recommendation of the Medical Director to establish an Advisory Committee of Nurses to act in the capacity of Advisors to the Medical Director and the Medical Council. Eight nurses, national leaders in nursing, social service, and public health nursing have been designated members of this committee.

The function of this Committee is to advise the Medical Director, the Medical Council, and its committees, on the above mentioned subjects, with the object of improving the nursing service to our disabled veterans. The following nurses have been invited to serve on this committee:

Miss Adda Eldredge, President, American Nurses Association.
Miss Laura R. Logan, President, League of Nursing Education.
Miss Clara D. Noyes, Director, Nursing Service, American Red Cross.
Major Julia C. Stimson, Superintendent, Army Nurse Corps, and Dean of Army School of Nursing.
Miss Elizabeth Fox, President, National Organization for Public Health Nursing.
Miss Lucy Minnigerode, Superintendent of Nurses, U. S. Public Health Service.
Miss J. Beatrice Bowman, Superintendent, Navy Nurse Corps.
Miss Harriet Bailey, Inspector of Nursing Schools, University of the State of New York, Albany, N. Y.

It is felt that the interest and coöperation of these leaders in the nursing profession will be of inestimable value and assistance to the nursing service of the Bureau by interpreting to the public what the Veterans' Bureau is doing for the care of the ex-service men.

This Advisory Nursing Committee will meet in Washington, D. C., at the time of the next meeting of the Medical Council which is composed of eminent specialists in the medical profession throughout the United States, who meet in Washington, D. C., from time to time to advise the Director of the U. S. Veterans' Bureau on vital medical problems.

MARY A. HICKEY,
Superintendent of Nurses.

THE RECOGNITION OF FAULTY POSTURE

By Lloyd T. Brown, M.D.

Boston, Mass.

SINCE the great war public opinion has become gradually, and in the last four years increasingly centered on the posture of the boys and girls of this country as a very important step in the physical fitness of the nation. The rejections during the draft of over 40 per cent of the young men of the country because of physical unfitness, was a great surprise to everyone, and the reaction in the interest,

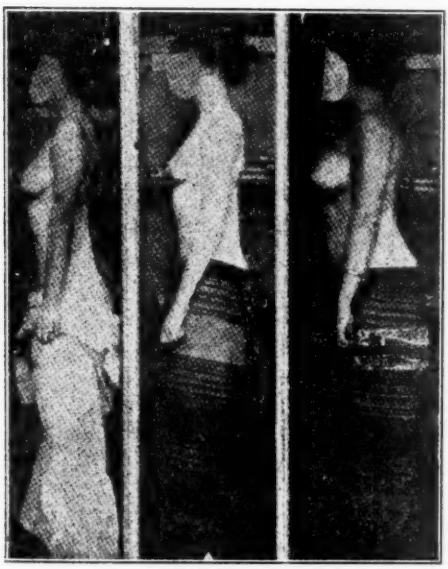


Figure 1—The three types of human anatomy. The Thin—The Intermediate—The Heavy. These three individuals are using their bodies in almost perfect body mechanics. They have been shown how to do so.

shown throughout the country, in bettering this condition, is one of the hopeful signs of our nation to-day.

Perhaps one of the most striking examples of this reaction is the work being done by our federal government in the various Citizens' Military Training Camps throughout the country. In the early days of these camps a great many of the men who came up for examination for entrance were rejected because of physical unfitness. The army, however, recognized that one of the greatest points in favor of the camps was the opportunity to give as many physically unfit men as possible a chance to become fit, as well as to learn the technic of being a soldier. The result of this feeling is that this year at one of the camps only one man was rejected, while 1,100 were taken in.

This means that it had been found that with proper training these unfit men, without interfering with the work of the physically fit, could be brought up to physical fitness, and so need not be discarded.

Recognition of faulty posture, or as it is better called, faulty body mechanics, is, of course, the first and most important step. Nevertheless, it is surprising how few people are able to recognize anything except the very worst conditions. There are many reasons for this, but the two most important ones are: First, lack of knowledge as to what is right and what is wrong; and, second, the common belief that since so many seemingly perfectly well people have postures so much worse than many who are sick, there is no relationship between body posture and health.

It is scarcely necessary to dwell on the second of these reasons because anyone who has ever given a moment's thought knows that as far back as records go, health and vigor and happiness have always been depicted by well-poised or well-shaped individuals, and sickness, fatigue or despondency by the reverse. There is more than artistic sense back of this. It is the result of countless years of experience among all peoples and races.

It is upon the first reason, namely, the recognition of faulty body mechanics, that the rest of this paper will dwell. Recognition depends on knowledge.

Our knowledge about this in the past has been influenced by the writings of many men who have described and tried to classify postural conditions by the amount of curve in the back, or the position of the shoulders, or the head,

or the abdomen, or some other condition.

This method has proved to be as inefficient as describing a house by saying it is made of brick and is four stories high. From such a description one knows nothing about the kind or color of the brick, nor whether the house has a square or a rounded front.

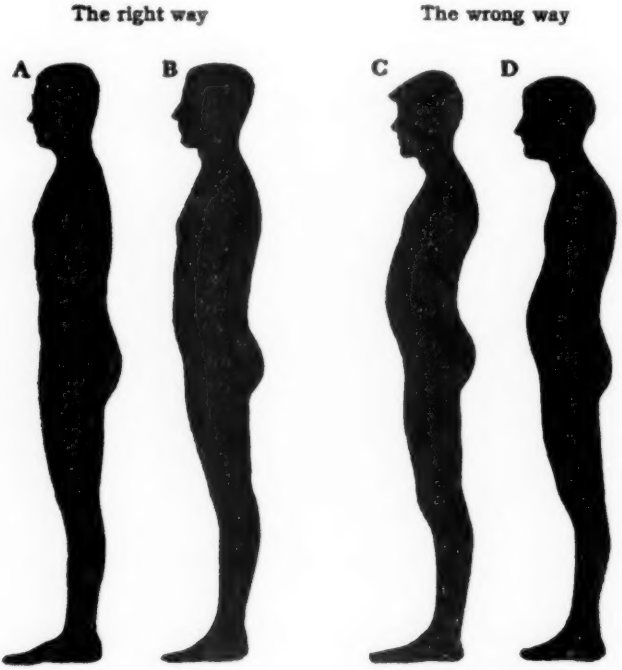


FIGURE 2—(A) EXCELLENT MECHANICAL USE OF THE BODY
1. Head straight above chest, hips and feet.
2. Chest up and forward.
3. Abdomen in or flat.
4. Back, usual curves not exaggerated.

(B) GOOD MECHANICAL USE OF THE BODY
(Compare with Fig. A)
1. Head too far forward.
2. Chest not so well up or forward.
3. Abdomen, very little change.
4. Back, very little change.
(Compare with Fig. A)

(C) POOR MECHANICAL USE OF THE BODY
1. Head forward of chest.
2. Chest flat.
3. Abdomen relaxed and forward.
4. Back curves are exaggerated.

(D) VERY POOR MECHANICAL USE OF THE BODY
(Compare with Fig. A)
1. Head still farther forward.
2. Chest still flatter and farther back.
3. Abdomen completely relaxed, "slouchy".
4. Back, all curves exaggerated to the extreme.

Each person reading the description pictures to himself the type of brick house that is the fashion in the city he comes from. So, too, with the posture of the body. We are influenced by the figures seen in fashion journals or the newspapers.

One must realize that no two human beings are alike. In a very rough way the human race can be divided into three types: The thin, the intermediate, and the heavy. See *Fig. 1.* There are very marked differences between the thin and the heavy type. These differences are seen not only in the outside shape of the body, but are also present in the bones and muscles and organs. The thin type is the nervous, high-strung individual, while the heavy type is the phlegmatic, more comfortable one who gets along very well with the world as a whole. Between these two extremes there is every possible combination and gradation of the two.

Since there are these marked differences in individual types so there will be every possible difference and gradation in the postures of these types. It is not possible, then, to make any comparison between individuals as to

the amount of lumbar curve or lordosis, or how prominent is the abdomen, or how rounded and drooped the shoulders, because what is a small curve

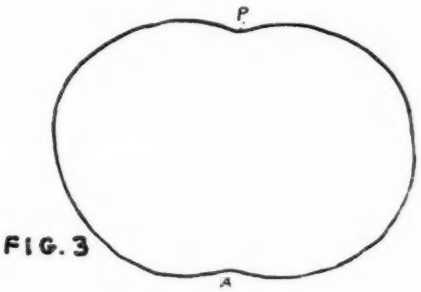


FIG. 3

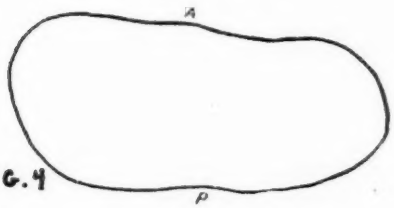


FIG. 4

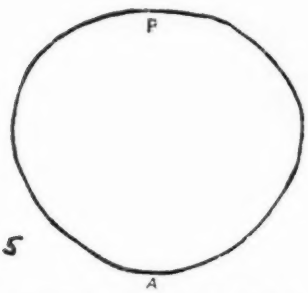


FIG. 5

Figure 3—The proper shape of the chest at the level of the tip of the breast bone. The diameter from front to back is about two-thirds of the diameter from side to side.

Figure 4—In flat chested persons, the diameter from front to back often does not measure half of the diameter from side to side.

Figure 5—The pigeon breast, in which the two diameters are about the same.

for one person may be a very exaggerated one for the next. Therefore, the comparison should be made between what each individual is and what his best should be. This makes it necessary that the examiner should know what the best should be for the individual being examined.

There are no exact rules or measurements which can be used to determine this, such as can be used in examining an engineering job, because, as can be seen from the above, no two individuals are ever the same. There are, however, certain points which can always be found and are of importance. Since simplicity is the keynote to success in any undertaking that is to last, the method of examination must be simple. For this reason the body can be examined for four conditions:

1. The position of the head.
2. The position and shape of the chest.
3. The position and shape of the abdomen.
4. The curves of the back.

Before going any further it is necessary to state very strongly that the relationship between these four is very close. Whatever happens to any one has its effect to a greater or less degree on all the others. Therefore, in judging the mechanics, all of the conditions must be taken into account. It will also be noted that the position of the shoulders is not mentioned. This is because they are entirely secondary to some or all of the four above conditions, and also that the correction of these shoulders must, of necessity, be secondary to the correction of the more fundamental faults.

Fig. 2 shows the chart used at Harvard University in the physical examinations of the freshman class. Each student is compared to this chart and is graded accordingly. The results of such grading have brought out the following:

	A.	B.	C.	D.
In 1920:				
513 examinations..	.99	14.81	49.31	34.89
In 1923:				
758 examinations..	2.64	20.84	49.87	26.65

The improvement that can be seen between the years 1920 and 1923 shows what has been accomplished so far by education in the secondary school.

Examination of a typical D posture shows some interesting points. The forward head means that the neck muscles have to tighten up to hold the weight of the skull in the forward position. When the head goes forward the chest flattens and the shoulders droop forward. With the flattening of the chest the abdominal muscles are relaxed and may become very prominent. With these three conditions there

must occur to a greater or less degree changes in the curves of the back. To counterbalance the weight of the forward head, the chest and the dorsal spine settle backwards, thereby making the round shoulders even more prominent. This, in turn, means that the lower back or lumbar curve becomes exaggerated or more hollow. It is a hollow back of this kind that is practically always found in the tired, aching back that is so common in people who stand long at their work.

Time and space will not permit the further discussion of other conditions which occur, but one should remember that with the changes in the shape of the body, shown above, there must, of necessity, be many other changes which may alter the shape and position of the thoracic and abdominal organs by taking away their normal supports. For example, in *Fig. 3* can be seen the shape of the chest in an individual with good body mechanics. Note that the relation of depth to breadth is about 2 to 3. In *Figs. 4 and 5* are two shapes commonly found in individuals using their bodies in faulty body mechanics. It can easily be seen that in the latter two there is much less room, and that the possibilities of crowding are much greater. Not only will the organs inside these chests have more or less impaired function but the muscles attached to the chest wall, such as the intercostals, the diaphragm, and the abdominal muscles, will also be handicapped in their function by the poor mechanical position in which they have to act. Take, for example, the diaphragm in its respiratory excursion. This can be very easily seen with the fluoroscope. In *Fig. 6-A* is shown the amount of excursion found in a person with good body mechanics, and *Fig. 6-B* the amount in a person with bad body mechanics. When it is considered that the diaphragm in its excursion not only fills the lungs with air, but also is one of the most important factors in pumping the blood out of the abdominal veins into the heart, the importance of the most efficient action of this muscle can be appreciated.

From what has been so briefly stated it can be seen that the habitual faulty use of the whole body must be considered as a potential of trouble rather than as a definite cause. Whether or not this faulty use of the body is the cause or the effect of malnutrition, indigestion, fatigue, or anything else, there can be no question but that its correction is a matter of prime importance, if for no other reason than as a preventive or prophylactic measure for the future.

The public health nurse, like the doctor, is ever confronted with the problem

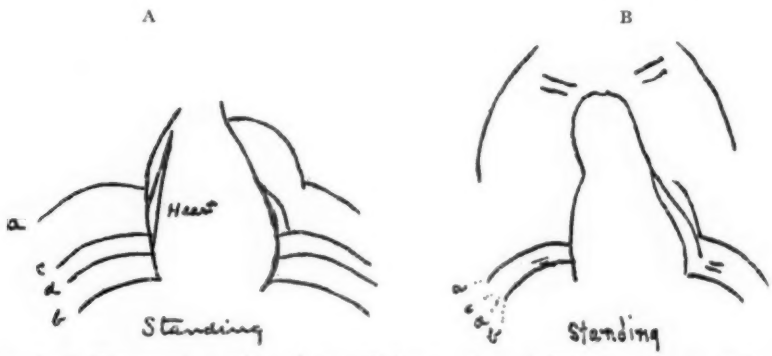


Figure 6—A. Fluoroscopic tracing of the diaphragm of an individual using his body in good body mechanics as in Figure 2.

a, position of diaphragm at full expiration.

b, position of diaphragm at full inspiration.

c, position of diaphragm at normal expiration.

d, position of diaphragm at normal inspiration.

B. Fluoroscopic tracing of the diaphragm of an individual using his body in bad body mechanics.

of what to do for these children. A great deal can be done.

The first thing, as mentioned above, is to recognize the condition. The second is to realize that the correction of it can come only by education and not by physical training as given in the ordinary way. If physical training could accomplish it we would not have had such statistics in the great war, and since.

The D posture (*Fig. 2*) is primarily one of fatigue. Whatever may have been the cause of the fatigue once the habit of faulty posture is acquired it is rarely, if ever, lost. To correct this habit it is necessary to educate the child how to use his body properly, first in the standing position, then in walking, sitting, and lying.

The series of pictures in *Fig. 7* shows the necessity of education for the child.

Fig. 7 (a) shows the habitual posture of a boy, (b) back view of same, (c) the boy's idea of the correct posture, and (d) the posture he was able to take as soon as he was shown what to do. All that is needed for the boy is that first he be shown how to use his body correctly, and then, that many times during the day the opportunity be made for him to come up to this standard as a part of his daily school work. It is here that education of the parents and teachers becomes of great importance.

For the malnourished, and especially the tired children, an opportunity to lie down once or even twice during the school period is worth more than strenuous play at recess time. The lying down period should not be spent curled up in a ball, but should be done with a pillow under the shoulders and chest and not under the head. This puts the chest and body in the best possible position for function and not only makes the rest more efficient, but also tends to stretch out the body and overcome the faulty positions assumed in the upright posture. Sleeping without pillows at night is also of advantage.

As was said above it is only by the education of the child, the parent, the teacher, and even the employer of labor, that a marked improvement in the body mechanics of the people of our country can be obtained. There is no more powerful factor in bringing this education to the people at large than the public health nurse.

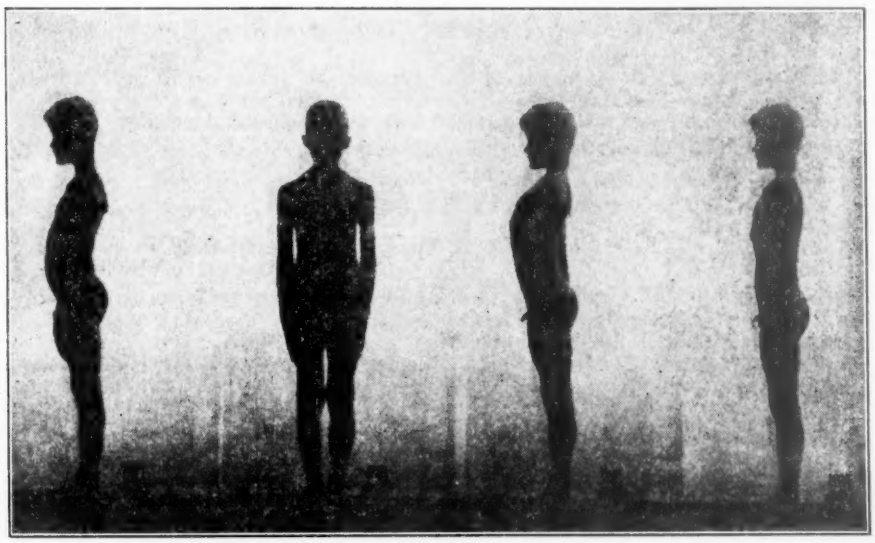


Figure 7—The result of education; A. Habitual standing position; B. Back view of same; C. The boy's own idea of correct posture—note the strained position; D. The correct position; easily taken after being shown how and what to do.

NEW HEALTH MOVIES

*Reviewed by the Health Films Committee, National Health Council**

PASTEUR

Length: Two reels.
Distributor: American Motion Picture Corporation, 71 West 23d Street, New York.
Rental: $10.00 per day and transportation. Sale at special prices.

The life of Pasteur, the great scientist, is presented, from early boyhood to the years of maturity and service to his countrymen and the world.

Briefly touching upon his early years, the film proceeds quickly to Louis Pasteur, the man, and his great scientific discoveries, significant contributions to the everyday life of man then and to-day.

Those who are eager to humanize the question of public health will welcome a picture of this type. The Health Films Committee commends this picture as excellent background material from which to proceed with a public health message.

The photography is excellent and the characters are well cast.

PETER MEETS A MENACE

Length: Two reels.
Produced by: Carlyle Ellis for New York Tuberculosis Association.
Price: Sale, $200.

Overfatigued by his regular daily routine of work and play, Peter suspects tuberculosis and visits a clinic, where it is discovered that he is a moderately advanced case. He is hurried at once to Saranac to take the "cure." After patient months of sanatorium life, he returns to his family and work, quite restored to vigorous health. Meanwhile his younger brother and sister have gone through outdoor school classes and preventorium.

To the general public the thought of "Saranac" is too often completely terrifying.

"Peter Meets the Menace" robs tuberculosis of this terror. From a passing interest in Peter's condition, which the audience experiences from the beginning of the film, they are led to a real desire for his complte recovery. The audience learns that Saranac is a place of beauty, of glorious walks and of happy companionship.

From a technical point of view, the film is scientifically accurate and well done photographically.

The Health Films Committee gave the film enthusiastic endorsement.

KEEPING FIT

Produced by: Pathé.

The seven "Keeping Fit" exercises developed by Dr. C. Ward Crampton, formerly Director of Physical Education for the New York City public schools, have been put into popular movie form under his direction. Each exercise is presented in a separate part-reel, the purpose being to show one exercise each week at the theaters included in the Pathé circuit.

Animated cartoons of droll little physical culturists, elaborate scenes of Greek dancers, pictures of the everyday modern man and woman impress the audience with the truth of the film's health teaching, ever old and ever new.

We understand that this series of films produced by Pathé is an outgrowth of the work of the Congress of Mothers' and Parent-Teachers' Association's Physical Education Committee. It is the first time that a commercial moving picture producer has entered the health field. As far as can be forecast by the Health Films Committee, this series should be a signal success.

* A new and revised edition of the mimeographed list of health films has been prepared by the National Health Council. The list, which contains data on over 300 motion pictures featuring health topics, may be obtained for 35 cents from the National Health Council, 370 Seventh Avenue, New York City.

WHAT SHOULD A COUNTY NURSE DO?

A Survey of Minnesota County Nursing Services

By Dora Peterson, R.N., and Ruth Houlton, R.N.
Child Hygiene Division, Minnesota State Board of Health

"WHAT should we expect of our county nurse?" "What are her duties?" "How can we as an advisory body direct our nurse's work when we ourselves do not know what her functions should be?" These are some of the questions constantly asked of the advisory nurse from a state health department by people interested in public health nursing in the rural districts.

On the other hand the rural public health nurses themselves are equally puzzled and interrogatory. "How can I best divide my time, considering all the different demands made upon me?" "Have I a right to take time for class work and talks when I know of so much case work to be done?" "I have a mileage for my Ford car of almost 1,000 miles per month. Does this mean I am not planning my work carefully?" These are examples of the many questions asked by the nurses.

In an effort to answer such questions as these through a study of existing county nursing services, a survey of the activities of 44 county nurses in Minnesota was made during the year 1923–1924 by the nurses of the Child Hygiene Division of the State Board of Health as they visited the county nurses in their fields. Of these 44 nurses, 21 were financed by county appropriation, 14 by local Red Cross funds, 8 by Red Cross and county funds used jointly, and one by other means. The information obtained through this survey, covering one year's work, can best be interpreted by means of the accompanying tables:

I. QUALIFICATIONS OF COUNTY NURSES

(1) Academic Education	
Number of nurses with full high school education	31
Number of nurses with less than high school education	13
Total	44
(2) Preparation for Public Health Nursing	
Number of nurses with adequate preparation	33
Number of nurses with public health course	20
Number of nurses with adequate experience	20
Number of nurses with both course and experience	7
Number of nurses with neither course nor experience	11
Total	44

Thus approximately 70 per cent of these county nurses have had the equivalent of high school education, while 7 nurses, or nearly 16 per cent, have had some or all of a college course. On the other hand, nearly 30 per cent have had as the academic preparation for their work less than a high school education.

In almost every case, the nurse with the better academic education has also acquired special public health nursing training or experience. Over 45 per cent of the nurses have taken public health nursing courses covering a period varying from 4 to 9 months. The same percentage has had experience in public health nursing which included, as a minimum, at least a year with a staff providing daily nursing supervision, or previous successful rural experience of at least a year, while nearly 16 per cent have had both course and experience, and only 25 per cent have had neither course nor experience.

II. TERRITORY

	Average	Maximum	Minimum
Number of square miles to one nurse	782	2,730	100
Number of people to one nurse	15,591	32,000	7,500
Number of school children to one nurse	3,073	17,000	950
Number of schools to one nurse	85	173	33
Number of people per square mile	20	67.3	6.5
Mileage per month	988	1,742	339

Table II brings out very forcibly the fact that each nurse has a territory and population so large as to make very difficult the proper division of her time and the meeting of the many demands made upon her.

V. EQUIPMENT

Number of nurses provided with car	44
Number of nurses provided with office (32 in Court House)	43
Number of nurses with small library of health reference books provided for them	9

EQUIPMENT OF COUNTY NURSES

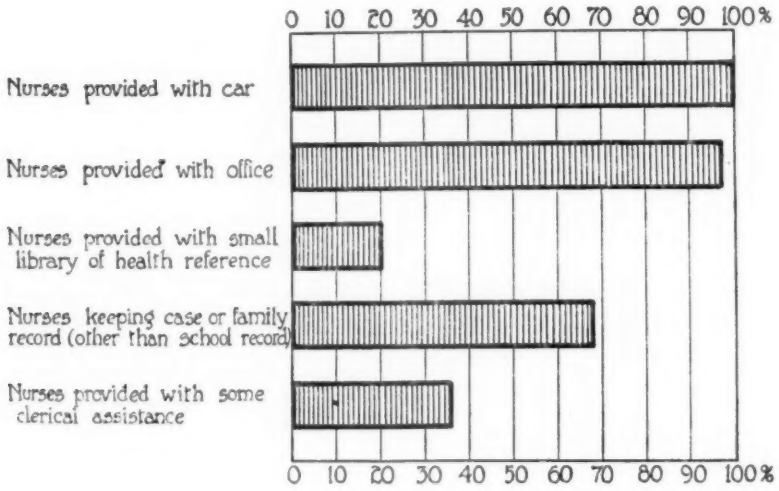


Chart I. Shows in percentages the equipment provided for municipal and county nurses.

III. COST OF SERVICE

	Average	Maximum	Minimum
Annual cost of service	2,654	3,600	1,800
Annual salary	1,812.4	2,100	1,500
Annual expenses other than salary	829.8	1,993	240
Cost per person in county	.17	.41	.08

The cost of a county nursing service, even at its maximum, is shown by this table to be negligible with regard to increasing taxes in the county.

IV. TYPE OF COÖPERATION

Number of services with active advisory nursing committee	24
Number of services without active advisory nursing committee	20

Since no county nursing service can be carried on with permanence and success without an active advisory board, the fact that hardly more than half of the nurses surveyed have such a group shows a lack of understanding of this need on the part of both nurse and public.

Number of nurses keeping case or family record (other than school record)	30
Number of nurses provided with some clerical assistance	16

The fact that a car and office are, almost in every case, provided for county nurses in Minnesota shows a decided advance in the understanding of their needs by the public within the last 3 years. On the other hand, though the need of nurses for clerical assistance is almost as great as for office space and a car, and 68 per cent of nurses keep case or family records, only 36 per cent are provided with clerical assistance.

Chart I shows in percentages the equipment provided for Minnesota county nurses.

VI. ACTIVITIES

(Percentage of time spent in each)

	Average	Maximum	Minimum
Educational	69.12	89	41
Mass	18.17		
Individual	50.95		

	Average	Maximum	Minimum
Case work	15.81	43	2
Bedside 4.86			
Contagious disease 3.22			
Social service.. 7.73			
Records and reports..	10.66	18	4
Meetings (administrative).....	4.41	12	2
	100.00		

ACTIVITIES OF COUNTY NURSES
(WITH REGARD TO TIME SPENT IN EACH)

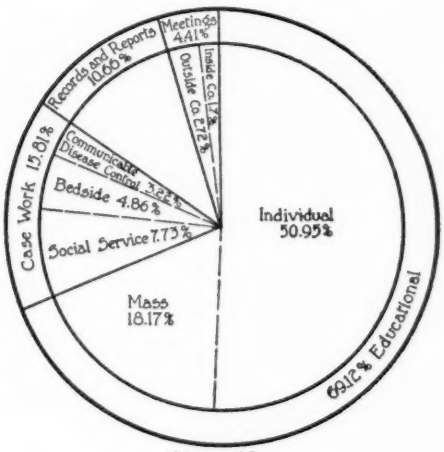


Chart II.

The percentages of time spent in various types of activities was based on a study of each nurse's work for a period of a year, as given in her monthly reports.

Under the heading "Mass Education" were put health talks to school children and others; printed articles published, form letters sent out; classes, exhibits, group demonstrations, and clinics held. Under "Individual Educational Work" were classified individual inspection of school children, home visits of instruction and demonstration, and all individual interviews and letters. Activities with regard to communicable disease control form, of course, part of every type mentioned. These, however, were figured in percentages only under case work with regard to actual follow-up visits in the home.

Chart II shows in percentages the average time spent by county nurses in the various types of work.

VII. TIME SPENT WITH REGARD TO TYPES OF PATIENTS

	Average	Maximum	Minimum
Maternal	6.07	46	0
Infant and preschool..	11.85	41	1
School	60.02	96	31
Tuberculosis	9.20	25	1
General (including social service)	12.86	22	2
	100.00		

During the year of this study a tendency to decrease the amount of time spent with school children and increase that with mothers, babies, and the tuberculous was evident. This tendency is probably due both to the definite plans for work with the latter groups recently developed as a result of the passage of the Sheppard-Towner Act and the increasing number of county tuberculosis sanatoria, and also to the recent country-wide change of emphasis from the public health nurse to the teacher with regard to health education in the schools.

Chart III shows in percentages the average time spent by county nurses with the various types of cases.

At the time of the survey each nurse was asked to state what in her opinion

DISTRIBUTION OF COUNTY NURSES TIME
(WITH REGARD TO TYPES OF PATIENT)

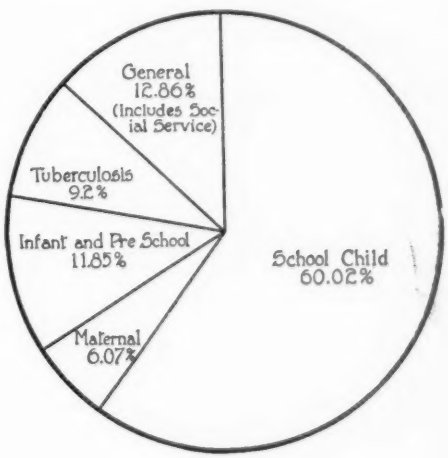


Chart III.

were the chief factors within her county for the success she had gained and also the outstanding problems still to be solved there. The answers are given below in the order of the number of times mentioned.

FACTORS IN SUCCESS

(Stated by individual nurses)

	Mentioned by
1. Classes, talks (to women's clubs, Farm Bureau clubs, parents in school), health programs, exhibits, and pageants	19 nurses
2. Home visits, particularly bedside care in emergency and for demonstration	13 nurses
3. Coöperation of county superintendent of schools (talks and round tables at Teachers' Institutes a help)	12 nurses
4. A truly helpful advisory board	8 nurses
Made more effective by	
1. Some one leading member prominent in community	4 nurses
2. Definite work assigned to members	1 nurse
3. Refreshments served at meetings	2 nurses
5. Successful work done by previous county nurse	8 nurses
6. Publicity through newspapers	4 nurses
7. Work with school children, *e.g.*, weighing and measuring, establishing competition between schools	3 nurses
8. Doing some social case work in addition to health work... (County Commissioners see material saving in care of poor, mothers' pensions, etc.)	3 nurses
9. Active coöperation of ministers and churches	3 nurses
10. Coöperation of physicians... (Special efforts made by nurse to win coöperation of physicians by frequent calls for advice, referring cases, assisting in emergencies, etc., stated by 19 nurses.)	3 nurses
11. Assistance of women's organizations	3 nurses
12. Interviews with influential people in all parts of county at every opportunity, *e.g.*, County Commissioners, citing cases	2 nurses
13. Coöperation of County Agent	2 nurses
14. Tuberculosis work in connection with local sanatorium..	2 nurses
15. Prompt attention to communicable disease calls	1 nurse

OUTSTANDING PROBLEMS STATED BY INDIVIDUAL NURSES

1. How to obtain active advisory board	8 nurses
2. How to win coöperation of medical profession (indifference—antagonism)	8 nurses
3. How to avoid spending considerable time on social case work	5 nurses
4. Large territory and long distances	4 nurses
5. Lack of coöperation in communicable disease control	3 nurses
6. Lack of facilities for correction of physical defects when people cannot pay; care of chronics	4 nurses
7. General apathy	3 nurses
8. Quacks and cults attempting to practice medicine preventing proper correction of defects among children	2 nurses

It is interesting to note that nearly half of all the nurses studied mentioned classes and group talks as a large factor in the success of their work and that almost a third mentioned bedside care in this connection. Less than 20 per cent mentioned the local advisory board as a factor, although most of those who mentioned problems to be met stated the difficulty of developing such a board.

Thus far the chief value of this survey has been that it has shown each nurse studied where the weakness of her work in the past has been and the importance of a carefully planned program for the future.

For those conducting the survey the chief result is the definite information obtained on which to base sound advice not only to nurses but to the groups employing them. In so new a field the only basis on which to found opinions is obviously a study of work already being carried on. Only by finding out what is being done and left undone can a better plan for the future be made.

PROBLEMS IN CONNECTION WITH THE ADMINISTRATION OF WELL BABY CLINICS

By Mary V. Pagaud

Superintendent of Nurses, Child Welfare Association, New Orleans, La.

Editor's Note: The discussion which has been carried on in our pages on *"Can a Satisfactory Maternity Service be Carried on as a Part of a General Health Program"* has proved to be of such interest and stimulus, that we are asked to begin a similar open forum, taking up the problems of the Administration of Well Baby Clinics.

PROBLEMS in connection with well baby clinics are becoming increasingly acute as the pediatric training of the young physician improves and the number of well baby clinics increases. Letters to individual agencies have developed a widespread confirmation of these problems rather than providing solutions.

We are therefore presenting some of the more pressing of these problems, hoping that free discussion will help to clarify them.

How are agencies with infant welfare clinics deciding the following questions of policy?

1. *What income limit, if any, should be adopted for patients attending a well baby clinic?* Public health agencies are being called upon to decide, first, whether their well baby clinics shall be open to all children, irrespective of the financial resources of the family; secondly, whether this service should be limited to children whose parents are financially unable to pay for pediatric supervision of the well baby.

When pediatrics was a neglected phase of medical training, the attendance at well baby clinics might well have been open to all infants without regard to the financial resources of the family. But now that preventive pediatrics has an established place in medical practice, what should be the policy of the public health agency in limiting the free service offered by the well baby clinic? Shall we give to preventive pediatrics the same consideration we give to other branches of medicine and limit our free service to patients unable to afford the physician's fee? Can this be done, in fairness to the physician and without injustice to children?

If pediatric supervision is not provided free, will the parents be willing—even if they are financially able—to pay for this new form of care for their children? Have we yet been able to educate our families to the point where father and mother appreciate the ultimate economy of regular visits to a pediatrician? Is there a danger of protecting the economic interests of the physician at the expense of the patients by prematurely limiting the attendance at well baby clinics?

Or, is public health so important, so much the concern of the whole public, that it should not be restricted for the sake of any single group? Perhaps, like public education, public health should be a civic responsibility rather than a form of social service? Then should an unlimited free service be given by the private agency? Or should this be the function of the public agency only? Conceivably, public health centers maintained by public taxes should be open to the entire public, like their prototypes, the public schools. But should this be the function of the private agency, still often regarded as a "charity" by its contributors?

If income limits must be considered, either for the public or for the private agency, when is a family able to afford pediatric supervision for its children? If in common with the social service departments of hospitals, we decide that families with more than a given per capita income are able to pay for medical care *during illness,* to what extent should this income limit be raised when we consider the medical supervision of a well child?

Some years ago, the New Orleans Child Welfare Association decided that in justice to the young physician, to our contributors and to a large and still

unserved group of poor families, we should investigate the financial resources of families attending our well baby clinics. We recognized that patients who were refused admission to our clinics might fail to place their well children under the supervision of a child specialist. This exclusion did not, however, mean that nursing supervision would be withdrawn and we hoped that the nurses' influence would usually be sufficient to persuade the mother to select and consult a pediatrician. In the main, this has been true. In some instances, however, the nurses have failed and failure places a heavy responsibility on the nurse for the delays, even when this whole endeavor does not deny to the child the pediatric care that is so essential during infancy. Unquestionably this action has enabled the clinics to serve a larger number of patients financially unable to secure such care. It wins for the public health agency a measure of confidence from the medical profession.

The question here arises—Does the good will of physicians enable a well baby clinic to serve more children in the long run than could be served if the doors of the clinic were open to all children and physicians felt that the preventive side to their pediatric work was being undermined by the multiplication of well baby clinics?

2. *How shall the financial status of patients be determined?* If the financial status of a family is to be determined, is it sufficient to ask the occupation and income of the wage earners in the family and accept the statement of the family, or must an effort be made to verify these statements?

If the income of the family is verified, to what extent shall the standard of living factor? Shall the bank clerk's family on an income of $150 per month be placed on a par with a day laborer's family on the same income?

Is the clerical cost of verifying incomes an economy—securing maximum usefulness for limited funds—or is it an expense that should more properly be borne by the physicians who profit by it?

For several years the New Orleans Association has verified the family income by letter or telephone to the wage earner's employer and we have had the full and appreciative coöperation of the employers. But, granting a fairly accurate knowledge of the family income, what scale should be used to determine ability to pay? Should the same scale apply to school teacher and banana carrier alike?

We have made no allowance for variations in the standard of living, but exceptions to the general scale are made at the discretion of the Executive Secretary by whom all applications are considered. The cost of verifying—in our case the salary of an intelligent clerk—certainly is not justified by the number of cases whose income is found to exceed our limit. But the security it gives the Association in knowing definitely that the clinic service is not abused, and the confidence it wins for the Association both from physicians and from the employers more than compensates for the cost.

3. *When shall prescriptions be given in a well baby clinic?* If physicians who are unwilling to undertake the feeding of infants are encouraged to send their patients to the well baby clinic and are assured that their patients will be sent back to them when illness occurs, when, if ever, should a prescription be given at the well baby clinic? Take the case of the child with a so-called "common cold." If the mother's income is meagre, she will not voluntarily take the baby to see her physician until the cold becomes aggravated or develops into one of the many respiratory diseases. Is it legitimate preventive medicine to prescribe at a well baby clinic for incipient colds and so prevent subsequent illness? If it is, where then should the line be drawn between incipient illness for which prescriptions should and should not be given at well baby clinics?

4. *Shall physicians in charge of well baby clinics accept clinic patients as*

private patients when illness occurs? This is one of the most difficult of the questions that administrators face. The clinic supervises the well baby, but refers it to the family physician when illness occurs. Naturally, the mothers often wish to call in the clinic physician to attend the ill child. To deny a mother her right to this physician's services, under penalty of refusing to re-admit her to clinic, apparently works an injustice to mother and baby.

But if the physician accepts the ill child as his private case, will it not often happen that the mother, finding herself unable to pay the physician's fee, refuses to return to clinic and thereby forfeits regular pediatric supervision for her child? Is this routine care by the pediatrician of greater value to the child than the services of a particular pediatrician during illness?

What of the Association's obligation to the private practitioner who has sent his baby cases to the clinic for feeding advice with the understanding that they will be sent back when illness occurs? What if that family doctor is not a baby specialist and may not be able to treat the child in illness as skillfully as the pediatrician would have done? Are we hurting both mother and baby when the clinic physicians cannot attend the child? Or will the confidence of the general practitioner enable us to supervise the feeding of a substantial number of babies who would otherwise be deprived of this pediatric care?

For several years the New Orleans Child Welfare Association has asked her pediatricians not to accept clinic patients as private cases. First, because we ask the general practitioner to send his baby cases to be fed with the explicit understanding that these cases will be referred back to him whenever illness occurs; secondly, because of the repeated instances in which the mother has called the clinic physician to her home, found herself unable to pay the fee, and resolutely refused to return to clinic. Of course, mothers who are not allowed to call in the clinic physician do not always return to their family physician. Some come to realize that pediatricians are usually better trained in the care of children than the average general practitioner and if the clinic physician is not available, call in some other pediatrician. Perhaps the time is coming when we shall be unable conscientiously to ask physicians to send their feeding cases to us. But, will the time ever come when we can agree to have the clinic physician accept the clinic patient as a private case without injuring the clinic attendance and perhaps the patient in question? Mothers who attend the well baby clinic are presumably unable to afford the regular supervision of a pediatrician. If through debt to the physician or by penalty of the Association, they are deprived of this routine care, do they suffer more than the loss of the physician's services during illness? The New Orleans Association thinks so, and their patients are told that they may not call in the clinic physician in time of illness without forfeiting their right to return to clinic. But what do other agencies think?

If these and similar questions can be discussed in the pages of THE PUBLIC HEALTH NURSE administrators of well baby clinics will be greatly benefited.

MUCH IN LITTLE

The mighty oak tree from an acorn towers;
A tiny seed can fill a field with flowers;
One bell alone tolls out the death of kings;
In every Sussex skylark Shelley sings.

Charles Dalmon—In the London Mercury.

PUBLIC HEALTH NURSING IN HOP YARDS

By Ruth Huff Douglas, R.N.
Bureau of Public Health Nursing, Oregon State Department of Health

PUBLIC Health nursing has recently entered an interesting field in Oregon, that of work among families on hop ranches. Deplorable conditions common on the larger ranches have, in the past, been considered necessary evils, owing to the peculiar nature of the harvest. A tremendous proposition confronts the hop producers throughout the state each September, as the fields cover hundreds of acres and all must be harvested quickly in a season of three or four weeks. Migratory families, carrying tents and scant household goods, have, of necessity, been depended upon to do a large part of the work. The conditions arising as a result—bad sanitation, immorality, petty crime, abuse and neglect of infants and children—were tolerated because there seemed no other way of harvesting the precious crop without disastrous delay.

One of Our Groups

Within the past two years a consciousness has arisen that social welfare work among the harvesters is good business, that conditions may be improved without additional cost. The first experiment was made in 1923 on the Horst Ranch. Its object, to improve the morale of the adults through a broad social program, has been attained and on this ranch the work has become established. From a public health standpoint there is still much to be desired, however, as the infants and children have been too little considered.

This fall, the owner of the Bell Ranch whose fields cover one hundred and seventeen acres, wishing to start a service suitable to the needs of his ranch, decided upon a playground and day nursery for the little ones and a first aid service for all. The advice of a field worker of the National Women's Council of Home Missions aided him in fitting up a splendid playground. This philanthropic organization offered further assistance, their purpose being to demonstrate how inexpensively such a plan might be carried out by the smaller ranches. But the ranch owner, preferring to adhere to a strictly pay basis, chose to employ a public health nurse, place her in charge, and leave all details of additional personnel and program to her discretion. His object was a business, not an altruistic one, as he wished to determine whether families would feel sufficient appreciation to keep them working faithfully and bring them to the Bell Ranch when

pickers are scarce. Only two requirements were made as to a working plan. One was that families be allowed either voluntarily to accept the assistance offered or to continue in their accustomed way, and the other, that the work be conducted as inexpensively as possible.

Starting the New Enterprise

So the early days of September, 1924, witnessed the beginning of the first public health nursing enterprise in this new field. The playground was ready, first aid equipment was quickly assembled and the one-woman organization began to function with much caution and a little fear and trembling. The need of an assistant to the nurse was immediately seen and a young woman trained in handicrafts was secured. By the third day our personnel was complete and a tentative program was ready for a trial.

Announcements telling of playground, nursery and first aid were posted in the two camp stores before hop picking was begun; no further attempt was made to gather in the children. The smallest groups attending the playground and nursery were fifteen, the largest forty-eight, ranging in ages from twelve months to twelve years. They were as varied in personality as in age; some had been carefully trained but others had seemingly "just growed," like Topsy; a few had been isolated from other children and did not know how to play, while others were almost constantly in some mischief. But irrespective of age or temperament, one and all must be kept safe and happy from early morning until evening and sent home better children for having spent a day at the playground. The splendid equipment was easily half of the battle. Sand boxes and teeter-boards, swings, a gyrator and a fascinating metal slide were in active service for hours each day. Older sisters and brothers also made use of the swings and slide after work each evening. Even the ranch owner and the doctor in camp on a call were once seen coming down the slide with the children. So the playground promoted good fellowship, but the day could not begin and end with play. A systematic effort to teach some worthwhile thing was a vital part of our purpose. In the beginning a regular program was confidently attempted and found impracticable. The infants demanded much attention. Their cribs were heaps of clean straw in the first aid tent and under the trees in the playground. Though few in number they were mighty in voice, some being for the first time separated from their mothers and in process of teething. Then, too, the groups varied day by day and did not always agree on a common plan of action. So we were obliged to content ourselves with a flexible plan comprising voluntary play, organized games, simple handcrafts, singing, reading and telling stories, and sometimes a jaunt through the woods or a potato roast in the coals of a bonfire afforded a special treat.

Teaching Hygiene and Health

From the first we were confronted by a striking need for health education among the children, so personal hygiene was stressed in stories, talks, drills, and private conferences. The usual ground was gone over; proper care of teeth, uses of the handkerchief, bathing, food, fresh air, exercise, camp sanitation and kindred subjects. Though the briefness of the season with the children was a handicap, our close contact enabled us to make health ideas practical.

For instance, camp sanitation meant more to the boys and girls when, after a simple discussion of its meaning, we made a cleanup tour of the upper camp, returning with refuse to burn. We had found one camp in terrible shape. On a smeared wooden table out of doors the remains of breakfasts were reposing in the sun. Hornets and flies buzzed hungrily from open garbage pail to half eaten food, a pan of milk speckled with flies and three drenched hornets were crawling about in a bowl of half melted butter. The mother and others had left

the youngest, an eleven year old girl, to clean up camp and then go to the playground, but she had gone to the playground first. Realizing for the first time how her camp must look to others, the little caretaker was covered with confusion at our visit, but a few words of encouragement and the nurse's offer to help whenever necessary reassured her. Our policy of non-interference prevented a system of thorough inspection. But safe water supply, covered garbage barrels, sanitary toilets and clean tents furnished with fresh straw minimized the danger from the spread of disease.

We had a genuine incentive to make our teachings on care of the teeth practical. Out of the entire group of fifty children questioned, four had toothbrushes at camp. The forty-six who did not were given toothbrushes and entered upon a contest, the rule of which was that they should clean their teeth at least twice a day. The faithful were to receive two prizes, the better of the two the habit of a clean mouth, the other, a gift from the nurse. They were regular soldiers in the toothbrush drills and at the close of the contest several had remembered every time, while many of them had made splendid efforts. Spring water was dispensed from the nurse's galvanized pail into each one's labeled drinking cup at regular periods.

Before lunch time the children were lined up for washing of dirty hands and faces. The nurse's wash basin served them all and clean cloths collected from parents were the only washcloths and towels. It was no small task to practice cleanliness under these circumstances. Water was at times so scarce that it was treasured for cooking and dishwashing. But we managed to observe the fundamentals of sanitation.

Eating habits were universally bad, the traditional camp diet taking its usual toll of digestive disturbances. Food was sold in the little camp stores with no raise in prices through special arrangement of the ranch owner. But fresh vegetables, fruit and cereals to cook were usually not in stock so were omitted almost entirely from the meals. Milk was generally used, however.

As our policy prohibited home visits, it was only through the children or those already ill that a successful effort could be made to better conditions.

In all these ways the principles of personal hygiene were brought before the children and it was not surprising to see a general response in their daily habits. The eleven year old keeper of the unsanitary camp, before mentioned, had much needed talks, public and private, apparently without comprehending. When she came to the playground clean and neat one morning and remained so until the last, it was indeed a happy surprise.

Behavior problems presented themselves every day, though as a group the children conformed to our few necessary rules and responded readily to a system of honor and fair play. One trio of brothers were nonconformists. When they became incorrigible they were sent to their mother with a note, only to return in a couple of days ready to start anew. The most severe behavior blow dealt us came from two neighbor boys who had been sent from camp for rough conduct and disobedience. They arrived at camp the following evening laden with a large watermelon and other delicacies and presented them as a peace offering to the nurse. With fitting inquiry as to good intentions, the gifts were accepted and divided among the group, and the poorly clothed boys were advised to spend their earnings more wisely. Evening disclosed the sad fact that the treat had come from money stolen by one of the boys from his mother's hard earned savings.

First Aid

The first aid program proved to be needed in many different ways. There were bad cuts and sprains, poison oak and bee stings, spider bites and broken ribs, burns and infections, requiring prompt attention. Acute illnesses, minor and serious, received bedside care and instruction. One of the play-

ground lads was wretched with ringworm from scalp to lower limbs and three boys in an Idaho family were badly affected with impetigo, but these cases were treated successfully and the camp made safer for others. We were authorized to call a doctor when necessary and when the family were unable to pay the ranch owner assumed the obligation. However, anything savoring of patronage or charity was carefully avoided.

Conclusions

So began and so functioned the first public health experiment in an Oregon hop yard. Next year the work will be more intelligently planned and conducted. Though the short season, separate camp grounds and lack of precedent were handicaps, the splendid playground and the complete support of the employer and his family more than outweighed them. That parents did appreciate the consideration shown them was demonstrated by private acknowledgment to the nurse and a rousing cheer for the enterprise at the last campfire. The children were grateful, too, and it was with sincere regret that we packed up our equipment on the last day and went our several ways. We had become real friends in the three weeks of play and study together.

The cost of the project for equipment, supplies and salaries was less than one dollar per capita. The money value of the work cannot yet be accurately determined, though it is not likely a small increase in cost of production would induce a ranch owner to put up with the old conditions. The thing that assures success is best expressed in the words of the ranch owner at the close of the season: "Time will tell whether or not this work will pay financially, but from the standpoint of satisfaction it has been a real success."

The future of social service in this fertile field rests very largely in the hands of our trained workers. Opportunities will be presented that will challenge the best we can produce. What shall we do in the hop yards?

THE IMMIGRANT MADONNA

This Christmastide, America, I bring to you my son,
My baby son,
He comes with little heritage,
But his eyes are clear, his body strong.
He is ready for you to do with him what you will.
What will you?

Will you use him hurriedly for your quick ends?
And will you then discard him because he is worn out—and still a foreigner?
Or will you teach him, watch him grow and help him to be one of you,
To work with you for those great things you seek?

He is my son, America,
And all my treasure.
I bring him here to you—
And you, what will you do with him?

Helen Dwight Fisher—in Hygeia

CORRELATION OF OFFICIAL AND UNOFFICIAL HEALTH AGENCIES IN A PUBLIC HEALTH PROGRAM*

By Charles F. Wilinsky, M.D.

THE correlation of official and unofficial health agencies and their respective places in the public health program has been much discussed in the past. It was the subject of an interesting symposium at the national meeting of the American Public Health Association in San Francisco in 1920, with Dr. Haven Emerson ably presenting the viewpoint of the public health agency and Dr. Charles Hatfield that of the non-official group.

Many opportunities have presented themselves for a demonstration of the theories advanced. It was agreed that leadership must rest with the public health agency. It is only fair that the public health officer, held responsible for the health of his community, must lead. Wherever that leadership has rested with the official health group, having the proper backing of the non-official agencies with proper correlation existing, much progress has been made.

Before we discuss the correlation of the two distinct groups, let us consider the existence and the function of the unofficial health agency.

Theoretically it might be said that the well organized up-to-the-minute health department would be cognizant of all of the essential services necessary and would supply them, leaving nothing for the unofficial group to do. Practically, we are far from that ideal day, and private agencies will be needed for a long time, if not always.

The well accepted community health program today, in addition to diagnosis and control of disease—a function of the public health agency alone—includes pre-natal instruction, baby welfare and child health education, social and mental hygiene, periodic health examination, anti-tuberculosis work, venereal disease control, posture and nutrition work, etc. Do health departments of even the best reputation and standing carry so complete a program? The answer is evident—and the reason is that the needs of so thorough and complete a program have not as yet been satisfactorily demonstrated to the taxpayer.

The justification for the existence of a non-official health agency in a community is the need of the particular service it furnishes in the neighborhood in which it functions. For this commendable endeavor it deserves credit so long as it combines with actual service rendered, an earnest effort to wage a campaign of education, exerting pressure leading in the direction of the taking over of its work by the municipality. The agency having this aim will be planning to educate the public to support the official health bodies in the establishment of the services which the non-official agency is then carrying on, and when it has succeeded in its purpose its work in that particular field is completed. Danger and misunderstanding lie in unwillingness to relinquish the field to the properly constituted official group. Too much stress cannot be laid upon the fixed duty of the private agency to throw support to the official public health group in the development of such a complete and thorough program that it may mean the effacement of the private agency or at least of the particular phase of the work in which it then may be interested and engaged.

While this is going on correlation must exist, duplication must be avoided, friction must be eliminated, false beliefs must be dispelled, and in this both groups must play a part.

The objective of both the official and non-official agencies, if they are well meaning and conscientious, is the same —the establishment of a complete health program for community good. That being so it is the duty of the non-official agency to help in creating favorable public opinion for the estab-

* Given as part of the discussion at the Public Health Forum Session, Annual Convention of the American Public Health Association, Detroit, October 23, 1924.

lishment municipally of the services deemed necessary and worth while; in the meantime, to fill the gaps that exist.

Value of the Non-Official Agency

The value of the non-official agency lies in its ability to carry on a service deemed essential in the public health program, which for a time the municipality fails to recognize as essential, or, through budget limitations, is unable to carry on. This period may be regarded as an experiment or demonstration of a justifiable piece of work.

In the field of research and health education the unofficial health agency finds fertile soil and is unhampered by the many limitations of the official health officer whose budget may permit him at this time to tread only the well beaten paths.

I have no new ideas or plans to contribute to this discussion, but wish to emphasize the fact that the deductions made in 1920 have been proved in many instances to be sound. Wherever intelligent correlation has been carried on progress has been made. Demonstrations and experiments of value carried on by private agencies have been taken over by the public health group, leaving the non-official agencies new fields to conquer and new theories to evolve. Is not this an interesting situation? Does it not prove the value of the private or non-official health agency in its chosen field and sphere? Does it not justify the commendation of the intelligent health officer who ought to welcome such an ally? On the other hand, should not the conscientious, farseeing private health agency be grateful to the constituted public health authorities for assuming their burdens? Should not non-official health agencies strive to work in close accord and harmonious relationship with the plans and programs of the public health group, supplementing these without duplicating, without competing with an established service functioning under municipal direction, and recognizing the principle that leadership should rest with the constituted public health agency?

So far we have been dealing with generalities, but I would like to give an instance of a concrete demonstration of these theories.

Demonstrating the Theories

It has been my privilege as Director of the Blossom Street Health Unit, maintained by the Boston Health Department, to work in close correlation and to assist in the development of a coördinated program which calls for combined efforts of the official and non-official group. It has again been my privilege and good fortune as Executive Secretary of the Boston Health League to assist in the development of a correlated piece of work with approximately thirty distinct official and non-official health agencies interested in the development. It has taught me as a representative of the official group, as it must have taught the representatives of the private agencies, that each group for a long time had the wrong perspective. From this contact has developed a better understanding and appreciation of the ability and willingness, as well as the limitations, of each member of the group—and the result has been a better health job. The city has taken over many of the services and burdens of the private agencies, in this way accomplishing the ideal objective.

As specific evidence resulting from correlation may be mentioned a recent development in Boston. For a long time infant welfare and child hygiene work have been carried on both by the Boston Health Department and the Baby Hygiene Association, which recently consolidated with the Instructive District Nursing Association, forming the Community Health Association. Excellent work had been done in infant and child welfare by the non-official group and yet until the friendly contact of the two agencies there was much duplication and waste of effort. This correlation has largely eliminated both duplication and overlapping. Not content with this progress, both the official and non-official groups worked for the absorption of this service by the proper agency to carry on this work, namely,

the City of Boston Health Department. This result came about from the existing correlation and the preceding working arrangement of about two years' duration. From personal contact and observation the belief and admission that the city should do this work was developed.

The development of a dental service, municipally supported, functioned by the Forsyth Dental Infirmary personnel, is another evolution made possible by correlation.

The employment of nutrition workers by the city has been justified by the demonstration by a private agency of the value of this service in child health.

Health education developed by private agencies is now being carried on by the city whose citizens and officials have appreciated the importance and value of this type of education.

Team Work

Both groups must correlate and their programs must work together. The private agency is needed to supplement, to demonstrate, to experiment, to educate and to coöperate with the official group. The official group is needed to diagnose and to control disease and, as the legally constituted authority, to assume leadership and responsibility, and finally, to bear the financial burden.

Much can be gained by the development of a permanent organization, composed of representatives of official and non-official groups of health and welfare workers. From such organization will come not only personal contact but a direct understanding of the fixed duties and limitations of each group. Such understanding should not only do away with overlapping, but result in the proper placing of services, as well as the rights and prerogatives of each. It is reasonable and fair to suppose that there is as much intelligence in one group as in the other. It is reasonable to presume that both groups are willing to coöperate and play the game. The efforts of both groups are needed to fight disease and ignorance. In health work, as in everything else, the old saying runs true, "united we stand, divided we fall."

MEETING OF THE CHILD WELFARE SECTION OF THE N.O.P.H.N.

A special luncheon meeting of the Child Welfare Section of the N.O.P.H.N. was called during the Annual Meeting of the American Child Health Association in Detroit, October, 1924, to discuss the question of whether the Section should continue. Miss Sara B. Place presided.

It was moved, seconded, and carried, after considerable discussion that the Child Welfare Section of the National Organization for Public Health Nursing be continued, and that a definite program be worked out by which concrete assistance can be given to agencies and organizations interested in child health throughout the country.

The Nominating Committee presented a report which was accepted and voted upon. The following officers were elected for the coming year:

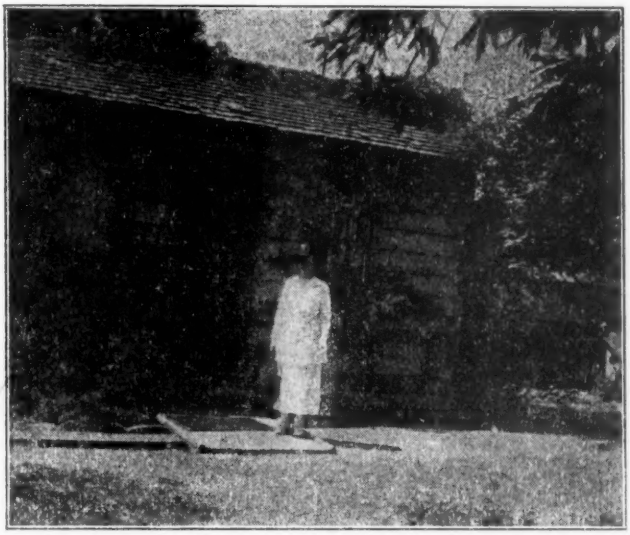
Chairman—Phyllis Dacey, Kansas City, Missouri.

Vice-Chairman—Mary M. Roche, Clinic for Infant Feeding, Grand Rapids, Michigan.

Miss Elinor Gregg, Supervisor of Field Nurses in the U. S. Indian Bureau, was introduced and gave a very interesting talk about her work.

DOROTHY ROOD, *Secretary*

BUREAU OF MUNICIPAL NURSING, DEPARTMENT OF HEALTH, LOS ANGELES, CALIFORNIA*



Bungalow used as headquarters for first municipal nurse in 1898

PUBLIC Health Nursing in Los Angeles dates back to 1898. Previous to that time a group of earnest women, known as the College Settlement Association, had been doing everything in their power to care for the poor in the community. Realizing the great need of nursing care for the indigent sick, in their homes (the Mexican fears a hospital), these women and the Health Commissioner appealed to the City Council for a monthly appropriation of $50 for the support of a district nurse. The request was granted and thus Los Angeles earned the distinction of being the first municipality in the United States to employ a visiting nurse. Her district was confined to that part of the city known as "Sonora Town." Her headquarters were at the College Settlement bungalow, at the corner of Alpine and Castelar Streets, where she also lived. From this small organization the work gradually developed.

In 1904 the first school nurse was employed by the Health Department, subject to civil service regulations, thus relieving the district nurse of that part of her responsibilities. In 1906 a second district nurse was appointed, and two more school nurses were added to the staff. The third district nurse was appointed in 1908, also a maternity nurse. A nurse was also appointed to act as inspector of children's boarding homes and day nurseries.

Infant welfare work was begun in 1910 when a milk station was opened at Bethlehem Institute, where the nurse modified milk prescribed by a physician who donated his services. Nursing mothers were also provided with milk when it was deemed necessary.

The first tuberculosis nurse was appointed in 1910 to work in conjunction with the Los Angeles Tuberculosis Society and to assist at the tuberculosis clinic, held at the College of Medicine.

In 1913 an ordinance was passed by the City Council, creating a Bureau in the Health Department, under the name of the Bureau of Municipal Nursing, conducted by a Commission. This Nursing Commission consists of five members who are appointed by the

* The seventh of the series depicting the homes and activities of voluntary, municipal and state public health nursing organizations.

Health Commissioner to serve without compensation for a period not to exceed four years, not more than three being of one sex, and not more than three being physicians and nurses. The Commission meets twice a month, receiving reports from the Superintendent of Nurses, conferring with and advising her in her administrative duties. The Commission acts in an advisory capacity to the Health Commissioner, making recommendations regarding the policies of the Bureau.

sponsible being small enough to enable her to give instructive and bedside nursing care, which includes prenatal, postpartum, baby welfare, tuberculosis, communicable and general cases.

Two municipal tuberculosis clinics are held daily, one children's open air clinic, two women's venereal clinics, three maternity clinics, nineteen infant welfare conferences, three runabout conferences, and five diphtheria immunization clinics. Each nurse is assigned to the clinics and conferences,

Baby welfare conference entirely Japanese

The Executive Office of the Nursing Division is at present housed with the Health Department in an annex of the old City Hall. A Civic Center and a handsome new City Hall are under construction. There are fourteen branch offices. The San Pedro branch is twenty-eight miles from the Central Office, the San Fernando Valley branch thirty-eight miles.

The organization at present is as follows:

Superintendent of Nurses and Assistant Superintendent of nurses
Six supervisors
Forty-nine staff nurses
Four inspectors of children's boarding homes, day nurseries, institutions, hospitals and sanatoria.
One stenographer, four clerks, and one maid in the milk station.

The city is divided into districts, an individual nurse being assigned to each, the district for which she is responsible being small enough to enable her to give instructive and bedside nursing care, which includes prenatal, postpartum, baby welfare, tuberculosis, communicable and general cases.

Two municipal tuberculosis clinics are held daily, one children's open air clinic, two women's venereal clinics, three maternity clinics, nineteen infant welfare conferences, three runabout conferences, and five diphtheria immunization clinics. Each nurse is assigned to the clinics and conferences, her schedule being changed every month. She also does the follow-up work in the homes of the patients attending the clinics and conferences, who live in her individual district.

The nurses also visit the twenty-three parochial schools in the city, teaching the children health habits, and visiting the parents of any child that is not perfectly well, calling attention to the correctible defects and those conditions which interfere with good health and good school work.

The Department's main problem is the peon, about 40 per cent of all cases cared for being Mexicans. Their standard of living is very low, and they require patient and persistent teaching on the part of the nurses. One baby conference at the harbor is entirely Japanese, and the effect of American diet on the Japanese stature is being watched with interest.

THE NATIONAL SOCIAL HYGIENE CONFERENCE

Annual Meeting, Cincinnati, Ohio, November 19–22, 1924

IT IS a pleasure and a privilege to those who are engrossed in the medical and social problems of venereal disease at close range, to meet and hear the discussions of men and women interested in the broader aspects of the problem. It gives new incentive, inspiration and courage with which to face anew each day's task.

Mrs. C. Neville-Rolfe, General Secretary of the National Council for Combating Venereal Diseases, London, England, spoke eloquently in favor of a closer alliance between all countries of the world to meet the forces of venereal disease and other social evils.

Miss Jessie Binford, Juvenile Protective Association of Chicago, cleverly drew a word picture of " Main Street " in the small town where the young men and women gather for their Saturday night amusement. She spoke of the one picture show which the town might possess with its sex appeal through its pictures and posters. She reminded us that Youth must have adventure, joy, romance, and if the home and those interested in the welfare of youth do not give it, youth will go elsewhere to get it. Miss Binford feels that the job of providing recreation for youth cannot be entirely met by municipally controlled parks, playgrounds and recreation centers. She pointed out that commercialized recreation resorts reach many more young people and are providing the things which they want—dancing, reception rooms, and community singing. She feels strongly that those interested in the social welfare of youth are losing a great opportunity by leaving out of their plans and conferences the great commercialized interests—theatres, publishers, musicians, dance hall owners, etc., believing that all would benefit by the joining of such forces.

Dr. Louis Pechstein, Dean of the College of Education, University of Cincinnati, spoke on " The Educational Relationship of Social Hygiene." Dr. Pechstein showed that the school's greatest contribution is to prepare boys and girls to be positive forces for good citizenship and proper living in their communities, to develop them to the point where they will back up the people who are putting over social legislation and to give them a thorough physical education and knowledge of biology and sociology.

Anna Garlin Spencer, Special Lecturer for Columbia University, chose as her subject " Building for Social Health." Mrs. Spencer brought out the " need for habit drill in service to the community." She urged that women mobilize in peace for the conservation of human life and hold high ideals for the youth of the land.

> You can never get youth so afraid of disease as to curb his passion, but must give his love of romance, his spirit of chivalry and adventure play. It is not well to teach him to avoid difficulties and dangers but to compass great aims by sacrifice. A lower plane of appeal will never reach youth where it lives.

Mrs. Mina Van Winkle, Lieutenant, Metropolitan Police Dept., Washington, D. C., spoke of the possibilities of the policewoman as a protective agent. She described her work in Washington — how policewomen have helped prevent crime, how they have contributed to the individual and to society, how they have helped first offenders so they might not repeat their offenses. Mrs. Van Winkle's paper was followed by discussions by Miss Elenor Hutzel, Deputy Commissioner, Women's Division, Police Department, Detroit, and Miss Inah Peterson, Director of Woman's Work, Police Department, Wichita, Kansas.

A special meeting not in any way connected with the Conference, but of value to nurses and teachers interested in sight conservation, was held with Mr. Lewis Carris, Director of the Society for the Prevention of Blindness. This meeting was particularly interesting, showing what a great factor teachers and nurses may be in conserving the sight of those who are handicapped by poor vision. Miss Fessenden, Physical Director of the conservation

of vision schools in Cincinnati, followed Mr. Carris with an outline of her plan of procedure in correcting faulty posture among the children in the sight saving classes.

In his address on "The Education of the Young," Dr. Max Exner showed how sex influences the world of thought, beauty, culture and all of life. The very words gallantry, manliness, womanliness, motherhood, fatherhood —all family relations—have grown out of sex influence and if removed would leave nothing worth while in their place. In the discussion which followed it was made evident, as it was at the earlier meetings, that sex education should be taught by appeal to the highest and finest instincts of children, and should be taught by means of physical education and that it should be an integral part of nature study and kindred subjects.

Sessions of the Medical and Publicity sections were held in the University of Cincinnati Medical School. In the Medical Session Dr. Edward L. Keyes, President of the American Social Hygiene Association, addressed the delegates on "Scientific Researches on the Venereal Diseases." In the discussions following Dr. Keyes' address much consideration was given to the questions of social service follow-up for clinic cases, and the necessity for providing adequate hospital facilities for cases requiring hospitalization.

LOUISE KUCK TUCKER,
Supervisor of Nurses, Board of Health, Cincinnati, O.

Teaching health habits in a country of 300,000,000 population, where the problem presented by the fact that there are 47 distinct languages spoken is further complicated by the extent of illiteracy present—according to the 1901 census, only one boy in five, and one girl in ten, was going to school—would seem almost an impossibility. The Red Cross Society of India, however, says *The World's Health*, has met the challenge with a series of propaganda booklets, liberally illustrated and with the lesson often pointed by a story. The brief text below the pictures is in the form of questions and answers. These booklets, which were originally issued by the United Provinces Public Health Department, are published in ten languages.

Thoroughgoing methods of fumigation are illustrated in the accompanying pictures. What could be more effective than the removal of the roof of one's dwelling that the rays of the industrious and beneficent sun may shine therein. Even civilization offers no such simple solution. And there seems to be no doubt in the mind of the artist that the method advocated for ridding a house of fleas results in very dead fleas indeed. (Note the dead fleas inset.)

Solar Activities

TRAINING OF MENTALLY HANDICAPPED CHILDREN

"WE have in the United States to-day 900,000 mentally handicapped children whose training is utterly neglected." Thomas H. Haines, M.D., backs up this seemingly startling statement by actual facts and figures in an article in *Mental Hygiene* on "Special Training Facilities for Mentally Handicapped Children in the Public Day Schools of the United States, 1922–23," of which we present a summary. Dr. Haines is the Director of the Division on Mental Deficiency of the National Committee for Mental Hygiene.

There were 18,102,792 persons from seven to fifteen years of age who were attending school in 1923 in the United States. Of these 45,719 were enrolled in special classes in day schools and about 25,000 in state training schools, some 70,000 in all. Yet in mental health surveys of 59,269 public school children carried on by the National Committee from 1914 to 1924 inclusive, in fifteen different states and from most diverse groups, 1,636 were diagnosed as "mentally defective" and 1,619 as "border-line mental defectives," all in need of special training. They constitute 5.49 per cent or 549 in each 10,000 studied. If this percentage holds throughout the United States, there were among the 18,102,792 children from seven to fifteen attending public schools in 1923, some 993,843 who needed special training because of their handicaps.

Training Suited to Needs of Children

Much confusion of opinion has existed in regard to the training best suited to the needs of mentally handicapped children. Some educators still measure capacity for training by capacity for learning to read or write or figure. Again, some educators and school administrators still hold to the view that feebleminded persons as such cannot be fitted for life in the community. Others hold that while such extra-institutional life may be possible for some feebleminded individuals, they can be trained for it only by a properly organized boarding institution; in other words that no feebleminded child is a proper subject for training in a day school along with so-called normal children. According to this view, feeblemindedness is an affliction that makes of the child so handicapped a training problem entirely "different" from that of the average child, so that he has no place in the ordinary day school even though he may be put in a special class.

The public school is responsible for the training of the children of the community. The responsibility for the training of problem children cannot be placed upon another agency or institution except as such other agency or institution is equipped for the special service. The school should either provide specially adapted training opportunities or see that the child has them offered him in a suitably equipped special training school. "The state training school for the feebleminded is a link in the chain of common schools —the last indeed, but still a necessary link in order to embrace all the children in the state." This was the belief of Dr. Samuel G. Howe, superintendent of the first school of the kind in the country, established in Massachusetts in 1848.

Dr. Haines takes issue with the argument which seems to run that all children who can reasonably be classed as mentally defective should be sent to these state training schools for all of their training, and proceeds to point out some fallacies underlying this reasoning.

While these training schools were established for the training of imbeciles and idiots, they have in practice received principally troublesome defective children, even of the higher grade of intelligence.

Under the modern concept of mental deficiency, mentally handicapped children are far too numerous to handle in existing state training schools.

To recommend such schools for many children who are really seriously mentally handicapped would be very

ill-advised. For many a feebleminded child, as for the normal-minded child it is an inestimable educational advantage to remain in his own private home, or even in a good foster home.

Personality Development and Special Classes

It is now plainly evident that education and training do not consist in securing information, but that there is in each child a *personality to be developed and trained. Even feebleminded children have personalities,* which must be developed if they are to be successful later as members of the community. The *special class for the mentally handicapped child* has been the answer of the public school to this need up to date.

In 1880 a beginning was made in Cleveland when a special class was organized but continued for only one year. Substantial beginnings in special class training were made in Providence, Rhode Island, and New York City in the middle nineties and have continued without interruption to the present time.

Many states now have special statutory requirements for the organization of such special classes in all school districts in which feebleminded children of school age exceed a stated small number. In some states aid is given from the state school fund to meet the higher costs of special classes as now organized. The canvass made by the National Committee indicates a great increase in the rate of development of such facilities in 1923.

Those Remaining

In spite of this there remain the 900,000 children, more or less mentally defective, for whom no provision has yet been made. Not until we have afforded them as good or better training facilities as are offered by the special classes and state training schools, concludes Dr. Haines, can we claim that our public schools are really undertaking the training and socialization of our mentally handicapped children. Until such facilities are provided, we are clearly neglecting our one most logical procedure for the prevention of the expensive delinquencies and dependencies of older defectives. The training methods used in the regular classes of the public schools do very little to organize their energies for the service of the community. By not spending more wisely for the training of these mentally handicapped children we are wasting not only what we do spend upon them, but we are wasting the children themselves.

Mental Hygiene for October also contains an article on "Feeblemindedness" by Walter E. Fernald, M.D. This article is written in especially clear and simple terms. Topics treated include: What Causes Feeblemindedness? What Are Some of Its Symptoms? How Is Intelligence Measured? What Kind of School Work Is Needed? Are All Defectives Vicious and "Bad"? The Sensible View to Take: A Hopeful Program. This article was written for inclusion in the third edition of *A Mental Health Primer*, published by the Massachusetts Society for Mental Hygiene. It may be secured from the National Committee for Mental Hygiene, 370 Seventh Ave., New York City, for 25 cents.

A brief account of the dedication of the new Boston Health Unit appeared in our December number. The *American Journal of Public Health* for December contains the very notable addresses delivered on that occasion by Dr. Haven Emerson and Dr. George E. Vincent. Any one feeling at the end of a long year of sustained effort a little fatigue over the question of the importance of their lives, or any others, of "public health" will, we think, find new inspiration to carry on from a perusal of these addresses.

CARE OF WORKERS IN SOUTH AFRICAN GOLD MINES

We reprint in somewhat briefer form an article which appeared in the November issue of *The Journal of Industrial Hygiene*. In "The Medical Care of South African Natives of the Gold Mines of the Witwatersrand," Lewis E. Hutslat, Mine Medical Officer and Railway Medical Officer, tells the interesting story of the mine "boys" and the excellent care they receive.

Courtesy Journal of Industrial Hygiene.

A Native First Aid Team

THE great bulk of South African mining is carried on in the area known as the Witwatersrand ("The Ridge of the White Waters") in the southern part of the Transvaal. The Rand, so-called for brevity, is a narrow strip of the high-veldt some seventy miles in length and one to two miles in breadth, 1,000 miles northeast of Cape Town, with an altitude of about 6,000 feet. Its climate is one of the best in the world.

The native workers engaged in the gold-bearing quartz mines of the district form the largest and most concentrated (single industry) labor force in the world. There are usually 184,000 natives employed in the mines. The average native stays on the work only a year as he has not yet acquired the habit of continuous work, and usually works only long enough to meet immediate needs. From 18,000 to 20,000 white men are employed by the mines as supervisors, skilled workmen, clerks, or officials.

The concentration of the labor force complicates some of the problems of hygiene, while simplifying much of the medical administration, as the South African native is, individually and *en masse*, extraordinarily amenable to control. All are of the Bantu stock. The vast majority come from homes where they live in a condition of semi-barbarism. Less than half of the men are married, and the average age is from twenty to thirty. The average height is 65 inches and the weight 127 pounds. No women accompany them to the mines.

As a worker the native is fairly reliable, under supervision. While at work the mine "boys" wear sacks and the white man's discarded rags. When not working the tribes vary considerably in their apparel.

About 80 per cent of the "boys" are recruited in the country districts by organizations that are subsidized by the mining companies, their fares are paid and money advanced to be paid out of wages. The rest pay their own way and come without encouragement.

Some walk hundreds of miles to the train. The average wage earned is two shillings per shift. A fair all-round wage per annum is thirty-three pounds. Food, living and sleeping quarters and medical attention are provided free.

Medical Examination

All natives recruited in the Union of South Africa have to pass a medical examination before being engaged by the recruiter. The standard of fitness is a fairly stiff one. The minimum age limit is eighteen. On arrival at the Rand the recruits are reëxamined. Every applicant is weighed and at some mines his height and apparent age are also recorded. Each "boy" is weighed monthly. This custom was instituted with a view to the earlier discovery of silicosis and tuberculosis of the lungs, two serious problems in the mines. All who are found to be in a seriously losing condition are subjected to further examination by the medical officer who decides whether they shall be given surface work, sent to the hospital, or sent home. In some mine hospitals the back of the weight card is used as a record for the medical history. Every admission to the hospital is entered. Inoculations are recorded.

Housing and Rationing

The native laborers are housed in a "compound," which usually consists of long rows of rooms built on the four sides of a great square, with all doors facing inward, windows on both sides and one gate for entrance and exit purposes. Signed permission from the compound manager is required if the men wish to go off the mine property. The rooms in the modern compounds are well ventilated and lighted, the walls are of brick and the floors and bunks are of concrete. Each room will hold from 30 to 100. The "boys" eat, sleep, and spend all their off-duty hours in these rooms. Bathing facilities are provided in separate buildings. Some of the tribes are scrupulously clean, others never seem to wash and are apparently none the worse for the abstention.

Rubbish is incinerated and water-borne sewage is utilized where possible. A gang of cleaners is kept constantly at work in the compound, disinfecting and whitewashing. Ceaseless warfare against insects is an essential factor in hygienic control.

A minimum ration is laid down by government regulation, and is supplied to the workers free and in a condition ready for consumption. It includes mealie-meal (Indian corn), the staple diet of South African tribes—eaten either as porridge or *mahewu*, a drink made from the meal mixed with flour—bread, beans or peas, germinated beans or peas, meat, peanuts, sugar, fresh vegetables, salt, cocoa, *kaffir*-beer.

It has been found that the native who drills rock by hand loses from four to five pounds in four to five hours. Those engaged in other work lose much less. This has to be considered in arranging the diet scale.

Sickness Average

The average monthly sickness rate in 1912 was 3.5 per cent; in 1923, 2.3 per cent. The average case duration was 13.5 days in 1912, 7.8 days in 1923. The average case mortality for the two years was 5.2 per cent and 4.1 per cent.

More than half the hospital beds are filled with accident cases. Septicemia was a serious factor in some mines up to recent years, since when intensive treatment and efficient first aid have largely minimized this risk. All natives not well enough to go to work are sent to the hospital or the dressing station, and if after treatment they do not become well enough to work, they are sent home under supervision, without completing their contract, at the expense of the mine.

All diseases except meningitis and diseases of the heart show a drop from 1913 to 1923, except for malaria which remains stationary. Accidents show a definite decline.

The marked improvement in the mortality is due to various factors, among which are: improved personal hygiene, gradually increasing immunity to certain diseases, the safety-first movement, more intensive hospital treatment, improvement of dust conditions underground, and the development of first aid among natives. Fortunately none of the epidemic diseases seem to spread very rapidly, nor are they severe in their effects. The very great improvement in pneumonia mortality may be laid in large measure to the fact that since 1918, all mine "boys" have been inoculated with anti-pneumococcal vaccine.

Most of the mines have their own hospitals for the natives, but in one instance there has been a centralization so that one hospital serves three or four adjacent mines. Resident hospital superintendents are responsible for the nursing and dressing arrangements and the training of orderlies. They are usually trained European male nurses. In two of the large hospitals white "Sisters" are in charge. But the greater part of the nursing is done by native male orderlies. A course of training is given the more intelligent, examinations are held and certificates of competence granted to the successful. A book on elementary nursing, with a vocabulary of 500 words in Zulu, Xosa, and Sesuto has recently been published.

Much valuable work for native health is done by the South African Institute for Medical Research, which is in Johannesburg. This institution is under the control of a board representing the South African Government and the mining industry, by which bodies its research work is financed.

The question of dust prevention, one that intimately affects the health of hundreds of thousands of native underground workers is met by sprays of filtered water in working places, water blasts, water-fed machine drills, water in the holes drilled by hand, and improved ventilation. The general average of dust underground has been reduced from 4.9 mg. per cubic meter of air in 1915 to 1.3 mg. in 1923.

The Native Affairs Department of the Government has a paternal concern for the economic and physical welfare of the natives and makes special regulations for their benefit. The Native Recruiting Corporation keeps in touch with all reported seriously ill and sends reports to their relatives. It has opened stores for their benefit.

There are scores of native churches and schools. Games are promoted for the more civilized workers. Special trains are run on Saturdays and Sundays so that the workers may visit from one compound to another. A special board has been organized to help them save money and arrange for transmitting their earnings to their homes. Tribal dances are a great feature with the East Coast natives, and competitions between large teams from the various compounds are systematically arranged and create vast enthusiasm.

A LIST OF NURSES HOLDING EXECUTIVE POSITIONS IN STATES

Editor's Note.—This list includes Directors of Divisions of Nursing and Nurse Directors of Divisions of Child Hygiene of State Departments of Health; State Supervising Nurses for the American Red Cross and the National Tuberculosis Association; Presidents of State Organizations for Public Health Nursing and Chairmen of Sections on Public Health Nursing of State Graduate Nurses Associations.

This list has been checked in every way possible with the help of the American Red Cross, the National Tuberculosis Association and State Departments of Health. Corrections or additions will be welcomed by he National Organization for Public Health Nursing. The last complete list was published in November, 1923.

State	Presidents of State Organizations for Public Health Nursing	Chairmen of Sections on Public Health Nursing of State Graduate Nurses Associations.	State Departments of Health	American Red Cross Nursing Field Representative	State Tuberculosis Association Field Nurses
Alabama			Jessie L. Marriner, Director, Bureau of Child Hygiene and Public Health Nursing, State Board of Health, Montgomery	Elizabeth Robison, *Southern Division*	
Arizona		Minnie C. Benson, 200 West Congress St., Tucson.		Mary Day Barnes, *Pacific Division*	
Arkansas	Linnie Beauchamp, Bureau of Child Hygiene, State Board of Health, Little Rock.		Linnie Beauchamp, Supervisor of Nursing, Bureau of Child Hygiene, State Board of Health, Little Rock	Helen B. Fenton, *Pacific Division*	
California	Mary Elizabeth Davis, Bureau of Child Hygiene, State Board of Health, San Francisco.		Mary Elizabeth Davis, Supervising Nurse, Bureau of Child Hygiene, State Board of Health, 336 State Building, San Francisco	Maria Johnson, *Pacific Division*	Ethel D. Watts, Supervising Nurse, California Tuberculosis Association, 418 Griffith-Mackenzie Bldg., Fresno
Colorado		Mrs. Ella May Livsey Maguiness, State Board of Health, Denver.	Mrs. Ella May Livsey Maguiness, State Supervisor, Public Health Nursing, State Board of Health, State Office Building, Denver	Mary Pritchard, *Southwestern Division*	Garnet Isabel Pelton, Executive Secretary, Colorado T. B. Association, 409 Barth Block, Denver
Connecticut	Margaret K. Stack, State Department of Health, Hartford.		Margaret K. Stack, Director of Public Health Nursing, State Department of Health, Hartford	Margaret K. Stack, *Washington Division*	Margaret K. Stack, State Department of Health, Hartford

Delaware		Amy E. Wood, 228 French Street, Wilmington.	Marie T. Lockwood, Supervisor of Nurses, State Health and Welfare Commission, Dover	Myrtie E. Taylor, *Washington Division*	
District of Columbia	Gertrude H. Bowling, 220 Washington Star Bldg., Washington.			Freda Johnson, 3208 17th Street, Washington	
Florida		Joyce Ely, P. O. Box 183, Perry, Taylor Co.	Mrs. Laurie Jean Reid, Director, Bureau of Child Welfare, State Board of Health, Jacksonville	Katherine Myers, *Southern Division*	
Georgia		Virginia P. Gibbes, Marietta	Anne L. Gallagher, Supervising Nurse, State Board of Health, Capitol Sq., Atlanta	Katherine Myers, *Southern Division*	
Idaho		Mrs. S. J. Ewen, Department of Public Welfare, State Board of Health, Boise	Mrs. S. J. Ewen, Assistant Director, Department of Public Welfare State Board of Health, Boise	Elizabeth Rohrback, *Pacific Division*	Mrs. Frances M. Wann, Director of Nursing Activities, Idaho T. B. Assn., Boise City Nat'l Bank Bldg., Boise
Illinois		Mabel McClenahan, 116 So. Michigan Avenue Chicago	Mrs. Madge D. Reiseman, State Supervising Nurse, Bureau of Child Hygiene and Public Health Nursing, State Department of Health, Springfield	Caroline A. Manger, *Central Division*	Anne L. Tillinghast, Supervisor of Nursing Service, Illinois T. B. Assn., 516 E. Monroe St., Springfield
Indiana		Elizabeth Melville, Newcastle	Isabel E. Glover, Director, Public Health Nursing, State Board of Health, Indianapolis	Mary M. Scantling, *Washington Division*	Isabel E. Glover, Newcastle
Iowa		Elizabeth Wyss Iowa Falls	Anna M. Drake, Director of Public Health Nurses, Bureau of Public Health Nursing, Department of Health. Des Moines	G. Elizabeth Reynolds, *Northern Iowa, Central Division* Lona L. Trott, *Southern Iowa, Central Division*	Anna M. Drake, Director of Nursing and Field Service, Iowa T. B. Assn., 518 Century Bldg., Des Moines
Kansas	Elizabeth Condell, 508 Riley St., Atchison			Pearl Laptad, *Eastern Kansas, Southwestern Division* Mary Pritchard, *Western Kansas, Southwestern Division*	

State	Presidents of State Organizations for Public Health Nursing	Chairmen of Sections on Public Health Nursing of State Graduate Nurses Associations	State Departments of Health	American Red Cross Nursing Field Representative	State Tuberculosis Association Field Nurses
Kentucky	Sue Parker, 538 Columbia Ave., Lexington.		Margaret L. East, Director, Bureau of Public Health Nursing, State Board of Health, Louisville	*Washington Division*	Margaret L. East, Bureau of Public Health Nursing, State Board of Health, Louisville
Louisiana		Mary Pagaud, 419 Maison Blanche, New Orleans		Elizabeth Robison, *Southern Division*	
Maine			Edith L. Soule, Director, Division of Public Health Nursing and Child Hygiene, State Department of Health, Augusta	*New England Division*	Edith L. Soule, Supervisor, Public Health Association, 318 Water St., Augusta.
Maryland	Marie Dandridge, Health Department, City Hall, Baltimore.		Lydia R. Martin, Chief Division of Public Health Nursing, State Department of Health, 16 W. Saratoga Street, Baltimore	Esther R. Entriken, *Washington Division*	
Massachusetts		Helen Fowler, Chief of Social Service, Out-Patient Dept.. Boston Lying-in Hospital, Boston		Erna M. Kuhn, *Western Mass., Southwestern Mass.* (A few towns) Mrs. Lyda King, *Eastern Mass., Northwestern Mass. New England Division*	
Michigan		Emilie Sargent, 286 Warren Avenue, East, Detroit	Mrs. Helen deSpelder Moore, Assistant Director. Bureau of Child Hygiene and Public Health Nursing, Department of Health, Lansing	Elba Morse, *Central Division*	
Minnesota	Ruth Houlton, State Board of Health, University Campus, Minneapolis.		Ruth Houlton, Superintendent of Public Health Nursing, Division of Child Hygiene, State Board of Health, University Campus, Minneapolis	Olivia Peterson, *Central Division*	

Mississippi		Mary D. Osborne, State Board of Health, Texas Bldg., Jackson	Mary D. Osborne, Director, Bureau of Public Health Nursing and Maternity and Infant Hygiene, Bureau of Child Welfare, State Board of Health, Jackson	Elizabeth Robison, *Southern Division*	Fay Truelove, State Tuberculosis Nurse, Mississippi T. B. Assn., Merchants Bank Bldg., Jackson
Missouri		Anna Heisler, Child Hygiene Division, State Board of Health, Jefferson City	Pearl McIver, Director, Public Health Nursing, Division of Child Hygiene, State Board of Health, Jefferson City	Alma Wretling, *Southwestern Division*	
Montana		Mrs. Ann K. Waring, Acton		Isabelle E. Carruthers, *Central Division*	
Nebraska		Margaret McGreevy, Central Division, American Red Cross, 660 Rush Street, Chicago		Margaret McGreevy, *Central Division*	
Nevada				Edith Chaffee, *Pacific Division*	Mrs. Martha O. Davis, Nevada Public Health Assn., Box 6, Reno
New Hampshire		Elena M. Crough, State Board of Health, Concord (Chairman is to be appointed every three months)	Elena M. Crough, Supervising Nurse and Director, Division of Maternity, Infancy and Child Hygiene, State Board of Health, Concord	Mrs. Lyda K. King, *New England Division*	Elena M. Crough, Supervising Nurse, State Board of Health, Concord
New Jersey	Helen Stephen, 65 Kenilworth Place, Orange.			Myrtie E. Taylor, *Washington Division*	Mary Carter Nelson, Executive Secretary, State T. B. Association, 9 Franklin Street, Newark
New Mexico	Ruth Moore, Las Cruces.		Matilda Harris, Chief Divisions of Child Hygiene and Public Health Nursing Bureau of Public Health, Santa Fe	Mary Pritchard, *Southwestern Division*	
New York	Mrs. Marion T. Brockway, Metropolitan Life Insurance, 1 Madison Avenue, New York City		Mathilde S. Kuhlman, Director, Division of Public Health Nursing, State Department of Health, Albany	Freda Johnson, *Washington Division*	Frances H. Meyer (State field nurse, irrespective of New York City and Brooklyn, which have their own field nurse), New York Charities Aid Assn., 105 E. 22d St., New York City

State	Presidents of State Organizations for Public Health Nursing	Chairmen of Sections on Public Health Nursing of State Graduate Nurses Associations	State Departments of Health	American Red Cross Nursing Field Representative	State Tuberculosis Association Field Nurses
North Carolina		Mrs. Blanche T. Lambe, 120 Schenck St., Greensboro		Katherine Myers, *Southern Division*	
North Dakota		Mabel Olson, Acting Chairman, Valley City		Isabelle E. Carruthers, *Central Division*	
Ohio		Marguerite Fagen, 2901 Vine Street, Cincinnati	V. Lota Lorimer, Chief, Division of Public Health Nursing, State Department of Health, Columbus	Clara Lodwick, *Washington Division*	Anne M. Carlton, Field Service Nurse, Ohio T. B. Assn., 83 South Fourth Street, Columbus
Oklahoma	Mrs. Bertha Gist, 1140 N. Broadway, Oklahoma City.		Luis G. Todd, Bureau of Maternity and Child Hygiene, Room 526 State Capitol, Oklahoma City	Helen B. Fenton, *Southwestern Division*	Mary Van Zile, 1318 East 15th Street, Oklahoma City
Oregon	Cecil L. Shreyer, 4th and Jefferson Sts., Portland.		Mrs. Glendora M. Blakely State Advisory Nurse, Bureau of Public Health Nursing, State Board of Health, Portland	Elizabeth Rohrback, *Pacific Division*	
Pennsylvania	Netta Ford, 42 Security Bldg., York.		Alice M. O'Halloran, Director, Division of Nursing, Department of Health Commonwealth of Pennsylvania, Harrisburg	Esther R. Entriken, *Eastern Pa.* Helen M. Erskine, *Western Pa.* *Washington Division*	
Rhode Island	Muriel Eales, Memorial Hospital, Pawtucket.			Edna M. Kuhn, *New England Division*	Elizabeth Sumner, Public Health Nurse, R. I. Tuberculosis Assn., 139 Mathewson Street, Providence
South Carolina		Laura Blackburn, State Board of Health, Columbia Bank Bldg., Columbia	Ada Taylor Graham, Director of the Bureau of Child Hygiene and Public Health Nursing, State Board of Health, Palmetto Bldg., Columbia	Elizabeth Robison, *Southern Division*	

South Dakota			Edith Olson, State Supervisor, Public Health Nursing, Division of Child Hygiene, Waubay	Anna Louise Kinney, *Central Division*	Merle Wilkin, Field Nurse, Public Health Assn., Huron
Tennessee		Malvina Nisbet State Department of Health, Nashville	Malvina G. Nisbet, Director, Public Health Nursing, State Department of Health, Nashville	Katherine Myers, *Southern Division*	
Texas	Arline McDonnold, Temple.		L. Jane Duffy, State Supervising Nurse, Bureau of Child Hygiene, State Board of Health, Austin	Mary Kennedy, *Southwestern Division*	Emma Ara Bacon, Public Health Nurse, Texas Public Health Assn., 616 Nettlefield Bldg., Austin
Utah	Mrs. Jessie Hammond, Civic Center, Salt Lake City.			Edith Chaffee, *Pacific Division*	
Vermont		Hattie E. Douglass, West Rutland		Erna M. Kuhn, *New England*	Nellie M. Jones, Public Health Nurse, Brandon
Virginia		Mrs. Jessie Wetzel Faris, Child Welfare Bureau, State Board of Health, Richmond	Nannie J. Minor, Director of Public Health Nursing, State Board of Health, Richmond	Alice Dugger, *Washington Division*	
Washington	Ella S. Erikson, State Board of Health, Seattle.		Ella S. Erikson, State Advisory Nurse, Division of Child Hygiene, State Department of Health, Seattle	Elizabeth Rohrback, *Pacific Division*	
West Virginia		Katharine Faville, Wheeling Chapter, American Red Cross, 1205 Chaplin Street, Wheeling	Mrs. Jean T. Dillon, Director, Division of Child Hygiene and Public Health Nursing, State Department of Health, Charleston	*Washington Division*	Elizabeth S. Arundale, Field Sec. and Field Public Health Nurse, W. Va. Tuberculosis Assn., 910 Quarrier Street, Charleston
Wisconsin		Clara G. Lewis, School Nurse, Eau Claire	Cecelia Evans, Acting Director, Bureau Public Health Nursing, State Board of Health, Madison		Nellie Van Kooy, Nursing Director, Wisconsin Anti-Tuberculosis Assn., 558 Jefferson Street, Milwaukee

State	Presidents of State Organizations for Public Health Nursing	Chairmen of Sections on Public Health Nursing of State Graduate Nurses Associations	State Departments of Health	American Red Cross Nursing Field Representative	State Tuberculosis Association Field Nurses
Wyoming			Louise Buford, Director, Maternal and Infant Welfare and Child Hygiene, State Department of Public Health, Cheyenne		Anna Krebs, Public Health Unit, Casper

SUPPLEMENTARY LIST

DIVISION DIRECTORS, AMERICAN RED CROSS PUBLIC HEALTH NURSING SERVICE

Director	*Division*
Mrs. Elsbeth H. Vaughan ..... 660 Rush Street, Chicago, Ill.	Central
Virginia Mason Gibbes ..... 75 Newbury Street, Boston, Mass.	New England
Dorothy Ledyard ..... Civic Auditorium, Larkin and Grove Sts., San Francisco, Cal.	Pacific
Jane Van de Vrede ..... 249 Ivy Street, Atlanta, Georgia	Southern
Olive A. Chapman ..... 1709 Washington Avenue, St. Louis, Mo.	Southwestern
I. Malinde Havey ..... National Headquarters, A.R.C., Washington, D. C.	Washington

Assistant Directors	*Division*
Annabelle Petersen	Washington
Elsie Witchin	Central
Elizabeth Robison	Southern

National Director, Home Hygiene and Care of the Sick

Mrs. Isabelle W. Baker.

FEDERAL AND RED CROSS NURSING SERVICES

Major Julia C. Stimson..Superintendent of Army Nurse Corps, Washington, D. C.

J. Beatrice Bowman.....Superintendent of Navy Nurse Corps, Washington, D. C.

Lucy Minnigerode .....Superintendent of Nurses, United States Public Health Service, Washington, D. C.

Mrs. Mary A. Hickey....Superintendent of Nurses, United States Veterans' Bureau, Wash., D. C.

Clara D. Noyes .....National Director, American Red Cross Nursing Service, Washington, D. C.

Elizabeth G. Fox .....Director, Bureau of Public Health Nursing, American Red Cross, Washington, D. C.

Elinor D. Gregg .....Supervisor of Field Nurses and Field Matrons, Indian Bureau, Wash., D. C.

METROPOLITAN LIFE INSURANCE COMPANY NURSING SUPERVISORS

MRS. HELEN LAMALLE, *Supt. of Nursing*

GENERAL

Supervisor	*Territory*
Alice Ahern, Asst. Supt.	Canadian
Alice C. Bagley ..... Asst. Supt.	Pacific Coast and Nova Scotia
Minnie H. P. Bridges...	New England and part of N. Y. State
Carolyn M. Hidden	Middle Atlantic and Metropolitan (N. J.)
Mary Elizabeth Tennant.	Southwest
Vera B. Warner.....	Middle West and Great West
Monica Moore	Southern
Ruth Waterbury.....	Group Nursing Supervisor

Local Supervisors

Teresa O'Neil	Long Island
A. Eugenie Atwell.....	Trenton, N. J.
Anna M. Barr	Alabama, Louisiana, Mississippi
Mary C. Dickerman.....	Jersey City
Catherine Ebbitt	Union Hill, N. J.
Emma Habernicht	Atlanta, Ga.
Mrs. Jessie Hammond....	Salt Lake City, Utah
Irene L. Harris.....	San Francisco, Cal.
Evelyn Horton	Camden, N. J.
Marie A. Houle.....	Quebec, Quebec, Canada
Clara McNamara.....	Scranton, Pa.
Mrs. Beulah Osborne.....	Rochester and western part of N. Y. State
Emma B. Rocque	Montreal, Quebec, Can.
Mrs. F. B. Whitworth....	Los Angeles, Cal.
Mathilda L. Johnson.....	Oak Park, Illinois, and suburbs

ACTIVITIES *of the* NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

Edited by ANNE A. STEVENS

BRANCHES OF THE N.O.P.H.N.

The following State Organizations for Public Health Nursing are now Branches of the National Organization for Public Health Nursing. In accordance with the provisions of the By-laws of the N.O.P.H.N., the Presidents of these branches automatically become members of the Board of Directors of the National Organization for Public Health Nursing.

State	Date of Affiliation with N.O.P.H.N. as a Branch	President	Secretary
Arkansas.....	June 14, 1924.....	Linnie Beauchamp, State Board of Health, Little Rock.	Mary McCall, Chamber of Commerce, Bradley.
California....	December 13, 1923	Mary E. Davis, State Board of Health, San Francisco.	Reba A. Ingols, State Board of Health, San Francisco.
Kentucky.....	May 9, 1923.....	Sue Parker, 227 No. Upper St., Lexington.	Virginia P. Martin, 227 No. Upper St., Lexington.
Maryland.....	May 9, 1923.....	Marie Dandridge, City Health Dept., Baltimore.	Constance Jacobs, City Health Dept., Baltimore.
Minnesota....	May 9, 1923.....	Ruth Houlton, State Board of Health, Minneapolis.	Marie Sargent, 436 Court House, Minneapolis.
New Jersey...	November 12, 1923	Helen Stephen, 65 Kenilworth Pl., Orange.	Margaret Hickey, Englewood Hospital, Englewood.
Oklahoma....	May 9, 1923.....	Mrs. Bertha Gist, 203 City Hall, Oklahoma City.	Mrs. Elmer Ellingson, 203 City Hall, Oklahoma City.
Oregon.....	January 17, 1923.	Cecil L. Shreyer, 22½ No. 20th St., Portland.	Esther E. Unis, 994 Michigan Ave., Portland.
Pennsylvania.	January 15, 1923.	Netta Ford, 42 Security Bldg., York.	Annie Laurie, 318 W. 8th St., Erie.
Rhode Island.	January 17, 1923.	Muriel Eales, Memorial Hospital, Pawtucket.	Carolyn Bliss, Providence D.N.A., Providence.
Texas.....	May 9, 1923.....	Arline McDonnold, American Red Cross, Temple.	Georgia MacKenzie, Austin.
Utah.....	December 13, 1923	Mrs. Jessie Hammond, Salt Lake City.	Mrs. W. W. Murray, Murray.
Washington..	May 9, 1923.....	Ella S. Erikson, State Board of Health, Seattle.	Ellen Joyce, City Health Dept. Seattle.

VISITING NURSING STUDY REPORT NOW AVAILABLE

The Report of the Committee to Study Visiting Nursing is now in circulation. Copies have been sent to all individuals and organizations requesting it, as well as to public health agencies, private and official.

A committee has been appointed by the National Organization for Public Health Nursing to consider problems and questions arising in relation to the study.

The Metropolitan Life Insurance Company is prepared to offer the services of an accountant to those organizations contemplating adopting the accounting systems recommended. Requests for the service will be considered in the order of their receipt.

It is earnestly desired that all questions, no matter how trivial they may seem, will be referred to the N.O.P.H.N., so that everyone may profit by the questions which arise.

A limited number of copies are available. Requests should be sent to the N.O.P.H.N., 370 Seventh Avenue, New York.

CENSUS OF PUBLIC HEALTH NURSING

In the November issue of this Magazine we published the general summary of the results of the Indiana Census of Public Health Nursing. The February number will contain a complete account of the Census in Rhode Island. This account will include a set of all the tables which are to be made for each of the other states, and also a narrative report. In an early number we will publish a general census report on a group of Southern states.

The following table shows the number of nurses in nonofficial public health nursing organizations in twelve large cities in the year 1919 and on the census day, January 1, 1924. On this day there were 196 more nurses employed in the total group representing these twelve cities than in 1919. This is an increase of 34 per cent.

FULL-TIME GRADUATE NURSES IN NONOFFICIAL PUBLIC HEALTH NURSING ORGANIZATIONS IN TWELVE LARGE CITIES IN 1919 AND ON JANUARY 1, 1924

City	Population 1920	*Number of Full-Time Graduate Nurses* 1919	January 1, 1924
(1)	(2)	(3)	(4)
New York*	3,016,119	175	208
Chicago	2,701,705	98	106
Brooklyn†	2,018,356	55	90
Detroit	993,678	49	68
St. Louis	772,897	35	41
Buffalo	506,775	38	48
Milwaukee	457,147	17 **	34
Kansas City, Mo.	324,410	21	45
Indianapolis	314,194	14	25
Denver	256,491	9	23
Toledo	243,164	28	34
Providence	237,595	38	51
Total number of nurses		577	773

The per cent increase in total number of nurses 1919–1924 is 34.

* Boroughs of Manhattan and the Bronx.
† Brooklyn Borough, New York City.
** 1920.

RED CROSS PUBLIC HEALTH NURSING

EDITED BY ELIZABETH G. FOX

EACH year at the time of the Annual Meeting of the Board of Incorporators of the American Red Cross, the National Committee on Red Cross Nursing Service holds its annual meeting. To those who like myself are just beginning to learn "what makes the wheels go round" in this nursing world of ours, a short account of the 1924 meeting of this Committee may prove of interest.

The National Committee on Red Cross Nursing Service is appointed by the Central Committee of the American Red Cross and consists of ten representatives from each of the three national nursing organizations (the American Nurses' Association, the National League of Nursing Education and the National Organization for Public Health Nursing) also, as *ex officio* members, the Surgeons General of the Army, Navy and Public Health Service, the Medical Director of the Veterans' Bureau, the Superintendents of the Army and Navy Nurse Corps of the Nursing Service of the Public Health Service and Veterans' Bureau, and the directors of the Nursing Services at National Headquarters. Three members represent the American Red Cross. To this Committee are presented all questions of new policies and procedures, as well as reports of the past year's work. Attendance at an annual meeting leaves one with two distinct impressions, first, the value of many differing points of view, and second the interrelationship of all national nursing interests.

Miss Noyes, Chairman of the National Committee, presided. Miss Fox spoke briefly of the more important developments of the year in the Red Cross Public Health Nursing Service. Outstanding was the growth of interest in and knowledge of public health nursing among chapter nursing committees.

After three or four years of experience many of our committees have come to have a firm grasp of the problems involved in public health nursing, a vital concern for the permanence and growth of their nursing service, and an intense pride in it.

Miss Fox said this was evidenced in their eager and informed discussions at Red Cross regional meetings, conferences of nursing committees and at the public health nursing round tables at the Red Cross Convention.

It is a matter of no small importance to the cause of public health nursing that it should gain a body of some (to be conservative) three or four thousand lay people distributed all over the country who are its enlightened and ardent supporters, working together with the nurse for its promotion.

Miss Fox went on to speak of the progress made in stabilizing the Service, saying:

Attention has been concentrated this year on strengthening the foundations of the existing chapter public health nursing services, rather than on increasing the number. Particular effort has been made to insure the permanence of these services under the auspices of the Red Cross as long as necessary, and ultimately under public auspices, and to promote their growth. Many services are now in their third or fourth year. Fifty-two chapters are now employing two nurses. Thirty-two chapters have more than two nurses, the highest number of nurses on a single staff being fourteen, exclusive of the Philippine chapter, which has eighty-one nurses.

This stabilizing of the Public Health Nursing Service is shown on the statistics. The reduction in the total number of services was only slightly over one-third as great this year as last. While the number of services newly established or reëstablished dropped from 207 to 148, about 25 per cent, the number withdrawn was over 50 per cent fewer this year than last.

Speaking of the work accomplished, Miss Fox gave this report:

During the year Red Cross public health nurses have made 1,162,330 home visits, have visited nearly 60,000 schools, and have inspected more than one and a half million school children. These figures are selected from among many other statistical items, and represent only a small fraction of the total record.

The itinerant public health nursing experiment which has been mentioned before in these pages was described and the various publications issued by the Service during the year were circulated among the Committee.

The outstanding feature of the past year's work in Home Hygiene and Care of the Sick as presented by its director, Mrs. Baker, has been the development of special courses for Home Hygiene instructors in the summer sessions of three colleges, namely, Simmons, Colorado Agricultural and Pennsylvania State. The two required subjects of each course were principles of teaching, and the practical presentation of Home Hygiene instructions. All other study was elective. Practice teaching groups were available in two of the courses. The instruction proved so successful and popular, that a similar course will be included in both the winter and summer program at Colorado and Pennsylvania State and in the summer program at Simmons. Meanwhile Home Hygiene continues to grow in popularity.

The reports of the various service directors was followed by the presentation of new plans and of special questions in the government nursing services which would affect the Red Cross Nursing Service. Major Stimson, Superintendent of the Army Nurse Corps, after giving an interesting account of the National Defense Day proceeding, went on to say:

> The preparation of Reserve Medical Units of the War Department is proceeding with slow but regular progress. . . . As soon as a director of one unit has been appointed he is sent instructions from the office of the Surgeon General regarding the nomination of a chief nurse, and the requirements for the assignment of reserve nurses. The most important sentence of these instructions is that reserve nurses are appointed by selection from the roster of the American Red Cross Nursing Service. At the present time eight chief nurses of units have been approved, and the nominations of seven others are pending.
>
> General hospitals will have a nursing staff of 120, evacuation hospitals, 60, and surgical hospitals, 20.
>
> The preparation in detail of these Medical Reserve Units is in accordance with the Defense Act which was passed by Congress prior to the World War, which has since been worked out by the general staff as a preparedness program with the idea in mind that the surest way to secure permanent peace is to be thoroughly prepared.
>
> It is not contemplated that the fact of being enrolled on the nursing staff of a Reserve Unit will interfere in any way with the daily occupation of any nurse. The willingness, however, of nurses to take their part in this preparedness program will be another indication that the nurses of the country can always be depended upon.

Both Miss Minnigerode, Superintendent of Nurses, U.S.P.H. Service, and Mrs. Hickey, Superintendent of Nurses, Veterans' Bureau, reported the introduction of bills in this session of Congress which, if passed, will create for their respective services a nurse corps similar in rating to the Army Nurse corps.

Mrs. Hickey, in addition, reported that the decentralization of the Veterans' Bureau and the subsequent establishment of regional offices in each state with subdistrict offices wherever needed would necessitate a change in the organization of the Bureau's nursing service.

> A head nurse will be appointed to each Regional Office. Her duties will be to act in an advisory capacity in directing the activities of the nurses in the sub-offices. Nurses assigned to this field of the Bureau's activities will be required to make contact and secure the ardent coöperation of all the nursing agencies in their respective districts. State, county and city nurse organizations and the American Red Cross nursing service will be utilized to the fullest extent, and the assistance of such organizations secured, whenever possible, for regular contact with the beneficiaries, and they will be requested to report to the nurse having supervision of the particular case in question.

Another development of interest within the Veterans' Bureau was the announcement that:

> The Director of the U. S. Veterans' Bureau has approved the recommendation of the Medical Director to establish an Advisory Committee of Nurses to act in the capacity of advisors to the Medical Director and the Medical Council. Eight nurses, national leaders in nursing, social service and public health nursing have been designated members of this committee.

It was fitting that the Chairman of the Delano Memorial should report the progress of her committee. The amount contributed to date is about $37,000, making a fund sufficient to justify proceeding with plans for the erection of a monument in Washington as a memorial not only to Miss Delano but to all nurses who died in service during the World War.

Miss Fox announced the appointment in December by the League of Red Cross Societies of Miss Alice Fitzgerald as special advisor to Miss Olmsted for a six months period.

The new uniform ulster for the public health nurses was heartily approved as were the models for new insignia to be worn on uniform hat, dress and cape by all Red Cross nurses on active duty.

Perhaps the announcement which warmed the hearts of those present and will have a similar effect on many other nurses, was Mrs. Kennicutt Draper's announcement of the continuation of the Red Cross Convalescent Home for Nurses, affectionately known to many overseas women as Bayshore. A legacy, and a yearly subsidy from the New York County Chapter, establish it permanently. A new home—a real country estate not far from New York City—has been purchased and the whole family from Bayshore is now moving into the new place of welcome and refreshment to the sick and convalescent nurse.

The meeting of the Nursing Committee immediately preceded the annual meeting of the Red Cross Incorporators. Ambassador Jusserand was the principal speaker at its final session. The closing statement of his address will be remembered for its beauty and its challenge:

> The American Red Cross is continuing the unfinished work begun long ages ago, when the star first shone out over Bethlehem on Christmas night. May it be faithful to its principles.

HELEN TEAL

List of N.O.P.H.N. members and subscribers whose mail has been returned. Can any of our readers supply addresses?

Abbott, Mrs. Adella G.
Beutenmueller, Olga H.
Bridston, Lydia
Dorsett, Mrs. Helen Esther
Doyle, Mrs. Elizabeth M.
Goddard, Mrs. Margaret B.
Grande, Miss J. Clara
Greene, Ellen Aikman
Heywood, Cora Lydia
Hodges, Lela
Hutchison, Mrs. Kathleen
Jacobson, Gerda Marie
Lewis, Rose L.
Moore, Velma E.
Replinger, Ethel Louise
Scott, Mrs. Thos.
Shanahan, Delia
Swisher, Grace
Walker, Norma T.
Wexler, Ella A.
Whittaker, Juliet A.
Woodward, Mrs. Anna C.

POLICIES, PROBLEMS AND SUGGESTIVE DEVICES OF PUBLIC HEALTH NURSING SERVICES

SUNDAY WORK

The Providence District Nursing Association sends the following questions:

Should time spent for Sunday duty taken in rotation with other nurses be made up?
Should all post-partum cases be visited on Sunday?

In reply we print the following statements from the Boston Community Health Association and from the Victorian Order of Nurses in Canada. We hope for further contributions to this interesting subject—which could be broadened to include plans for work on holidays (as has been done in the Boston account).

ARRANGEMENT FOR SUNDAY WORK IN THE BOSTON COMMUNITY HEALTH ASSOCIATION

FOR the past year the Community Health Association has had an arrangement for Sunday visiting which has worked out very well for both patients and nurses. Our aim has been to make Sunday a day of rest for the nurses, and to leave the families to themselves as much as possible, making visits only to those patients who would suffer from lack of nursing care for one day.

The number of Sunday visits is generally between fifteen and twenty, and from eight to eleven nurses work each week. In the winter the number of nurses was sometimes as high as fourteen, but this was exceptional, and each member of the staff is called upon usually not oftener than every eighth or ninth week.

The method by which the work is carried on is as follows: Twelve stations are divided into groups of four stations each, according to proximity. In each of these three groups, the most centrally located station is always open on Sunday morning from 8:30 to 9:00, and here the nurses meet who are to make visits in the districts of this group. Since it is seldom necessary to have one nurse from each station on duty every week, the assignments are made from the Central Office, so that as fair a rotation as possible may be obtained, and the nurses in the smaller stations may not be called upon much more frequently than those in the larger stations. There are three districts so far out of the city that they can not be counted upon to help other districts. Each of these three takes care of itself, assigning a nurse to Sunday work when necessary. The nursing service is not extremely heavy in any of these districts, so, although the number of nurses in each is small, they actually do not work more often than the nurses in the rest of the city. On Saturday afternoon calls for Sunday visits are given over from each station in the group to the station which is to be open. Late Saturday afternoon, the Out-Patient Department of the Lying-in Hospital, for which we provide the nursing service, is called for any new maternity cases which may be in special need of Sunday visits. The supervisor of each "Sunday Station" consults with the Central Office supervisor, and such assigned nurses as are not needed for Sunday work are omitted. We plan on a full morning's work for each nurse, but try also to make allowance for any emergencies which may come in, and allow for great distances between cases.

The Central Office is not open on Sundays. The doctors and organizations with whom we work most closely have been informed of the stations which can be reached on Sunday between 8:30 and 9:00. After 9:00 A.M. the nurses are not available until Monday morning.

The half day spent in Sunday work is made up to the nurse the following week, usually as a morning preceding her usual half day off duty, thus giving her one whole day away from the district. Because of the fact that the time must be made up during the week, great care is exercised in the stations in selecting the cases to be seen on Sunday, and under this new system, the number reported for Sunday visits has decreased from around 35 or 40 to about 15 or 20. However, although we wish to reduce the Sunday work as much as possible, we do try to err on the safe side. There is of course little danger that the needs of acutely ill patients will be overlooked. To guard against any possible neglect of maternity patients on that day, we have made a few suggestions to help the supervisors and nurses decide which ones shall have care:

Under almost all circumstances the following are indications for Sunday or Holiday visits:

1. Where there is no responsible person who can give satisfactory care.
2. Where condition of mother or baby shows variation from the normal, such as
   a. Sutures needing special attention.
   b. Instrumental or operative delivery with consequent weakened condition.
   c. Rise in temperature.
   d. Twins or premature baby.

The same routine is followed on holidays, except when the holiday comes on Saturday or Monday. On such days all the stations are kept open in the morning and as many nurses remain on duty as are needed to make the nursing visits. The stations are closed on all holiday afternoons, as they are on Sunday afternoons.

We still watch the Sunday work carefully and look for chances to improve it, but we feel that the general satisfaction with it and the absence of compliants from any source are an indication that the patients are receiving adequate care.

KATHARINE PEIRCE

We have a staff of forty-two nurses and have an average of over six confinements a day.

Our Sunday duty is divided as follows: Four nurses are on duty from 8:30 A.M. to 11 A.M. These four come on again at 11 P.M. and remain on all week from 11 P.M. to 7 A.M. Five nurses on duty from 11 A.M. to 3 P.M. These five have come off duty at 11 P.M., Saturday night. Five nurses on duty from 3 P.M. to 11 P.M. These five keep this duty for one week, on Sunday they are on call for confinements mostly, doing only the cases which require a second visit. The nurses coming off duty at 7 A.M. Sunday remain off all day. The rest of the nurses are divided either on duty from 8:30 A.M. to 1 P.M. or are having their long Sunday off. Every nurse has one whole Sunday off duty each month. We have a night supervisor who comes on at 8 P.M. and leaves at 7:30 A.M.

Our new maternity cases and any acute cases all have Sunday visits. There is no rule as to how old a maternity case must be. This is left to the nurse's judgment.—*Victorian Order of Nurses, Toronto, Canada.*

We carry only confinements, acutely ill and emergency cases on Sunday, and as our confinement service is very heavy we have to cover the full day. We try to arrange that the nurses have two Sundays off during the month, and to be on duty four hours during the other Sundays—their hours are usually from 8:30 to 12:30, 1 to 5, or 2 to 6 P.M.

This does not mean that a nurse is actually in the field, but we expect her to be in the District Office, or if she lives in her District we allow her to remain at home on call.—*Victorian Order of Nurses, Montreal, Canada.*

GENERALIZED OR SPECIALIZED NURSING

We print this editorial from the Nation's Health, November, 1924, as a good "follow-up" to the "Questions" on the same subject in "A Public Health Forum," page 656 of our December number.

There are points in this editorial which will raise other questions—we hope for a discussion of two or three specific ones in our next number.

In no field of public health administration does opinion and practice vary so much as it does with reference to the best plan of public health nursing. Administrators of equal authority hold conflicting opinions. Such differences of

opinion among those equally well qualified to judge usually indicate differences of viewpoint which, in turn, are dependent upon differences in conditions.

Conditions differ with time and with place and it is probable that there are times when the specialized plan of public health nursing is indicated and other times when the generalized plan should be followed; moreover, there are places where the specialized plan is most appropriate and there are other places where the generalized plan will give the larger service.

When in city health administration it is impossible to secure a sufficient force of adequately trained public health nurses, then the specialized plan of nursing may be indicated, not as theoretically desirable but as practically necessary. It is comparatively easy to train a nurse to meet some special public health problem—to teach a nurse to do tuberculosis work or prenatal work, or school work—and then to assign her to that special field of service. On the other hand, it is difficult to train a nurse to meet these three problems and additional ones, requiring years of general training where only months are necessary for special training. It is for this reason that, in the past many cities have rightly clung to the specialized plan of public health nursing. When, on the other hand, it is possible for a city health department to secure a sufficient number of adequately trained nurses for the generalized plan of public health nursing, then the generalized plan is, on account of its absence of overlapping service, of greater efficiency and of simplified administration, the plan of choice. This all means that as more nurses with adequate training become available for public health work, the specialized plan will gradually be transformed into the generalized plan of public health nursing.

An illustration of a local character makes clear this whole process of the transformation of the specialized plan of nursing into the generalized plan. In the city of Detroit for about 900,000 of its population the specialized plan of nursing is in operation. In the Delray district of Detroit, with about 100,000 population, the generalized plan is in operation. The relation between the two plans is that a nurse, after having been in specialized work for several years, having had experience in tuberculosis work, prenatal work, child hygiene, school work and other service, in short after having become possessed of general nursing training and experience, is transferred to the generalized plan in the Delray district. This perhaps carried to its conclusion will gradually convert the specialized plan of nursing into the generalized plan and the Delray district will be continually enlarged from the standpoint of public health nursing until it supplies the entire city.

In the February number we will begin a discussion on the following questions recently asked:

1. *Is it permissible for a nurse in the field to raise, lower or otherwise change the formula of a baby under her supervision?*
2. *How much responsibility can the nurse assume for a baby whose mother does not bring it to the conference and does not have a family physician?*
3. *How long should a baby be carried under these circumstances?*

Contributions to this discussion gratefully received.

We also hope to continue the discussion on *Transportation*, begun in December, and on *Physical Examinations for Staff Members*, begun in November, in our next number.

REVIEWS AND BOOK NOTES

The Report of the Committee to Study Visiting Nursing, instituted by the N.O.P.H.N. at the request of the Metropolitan Life Insurance Company, is now ready. This study was made to evaluate visiting nursing and to estimate the cost of visiting nurse service. A further note on this will be found on page 44.

WOMAN'S PHYSICAL FREEDOM

By Clelia Duel Mosher, M.D.

The Woman's Press, 600 Lexington Avenue, New York City, 1924, price $1.00.

"Woman's Physical Freedom" is the third revised and enlarged edition of Dr. Mosher's "Health and the Woman Movement." The keynote of this edition is given in a sentence in the preface—"The present stirring times demand women at maximum capacity for work every day in the month." As may be expected from the earlier editions, Dr. Mosher expresses herself in this one to the effect that women's "maximum capacity" is sufficient to meet all racial and economic demands—quite as sufficient as the capacity of man. With the proper health education and practical interpretation of that education in every day life, health is attainable for both. In order to make her position clear Dr. Mosher devotes by far the larger proportion of her book to a sane treatment of the subjects of menstruation and the menopause as natural — not abnormal — phases of women's physical life. Under the subtopics of cause of suffering, treatment, habits, etc., the cobwebs of preconceived notions of these phases are swept aside and the increase in one's physical and mental efficiency through ridding one's self of periodic suffering is made a much desired end. Outside of these two topics the book takes up the question of health habits in general, and the relation of dress to health. As a whole, the book is clear, forcible, practical, and most worth while for the effort made to bring women to face facts as they are.

LENNA L. MEANES, M.D.

THE FAMILY AND ITS MEMBERS

By Anna Garlin Spencer

J. B. Lippincott, Philadelphia. $2.00

This book, as stated in the introduction, is based on the thesis that the monogamic private family is a priceless inheritance from the past and should be preserved, but in order to preserve it, many inherited customs and mechanisms must be modified to suit new social demands. The tendencies at work toward such modification and adjustment are the theme of the book.

The chapters deal in detail with the various relationships of the family group: mothers, fathers, grandparents, brothers, sisters, husbands, wives, the child. A further differentiation divides the latter into the unusual child (those specially gifted or deficients) and the prodigal son and daughter. Other chapters are given to the family's relationship to the school, to the state, and to labor. Dr. Spencer's fund of knowledge and long experience in presenting her subject (she began her public literary career in 1871), together with her grasp of present-day tendencies and influences make this an interesting book and one that gives much food for thought.

MARY S. GARDNER

HOW FOSTER CHILDREN TURN OUT—A STUDY

State Charities Aid Association, 105 East 22nd Street, New York, $1.00

This interesting and significant book is based upon the results of a study and critical analysis of 910 children placed in foster homes by the Association, and who are now eighteen years of age or over.

The conclusions reached would seem to indicate that environment rather than heredity won out in this carefully studied group. It was found that approximately 80 per cent of these children came from "predominantly bad" backgrounds, and that 77 per cent turned out well, "able to manage their affairs with average good sense,

and who live in accordance with good standards in their communities."

We quote a paragraph from the summary of conclusions:

Our study of the group as a whole, in so far as the subjects have demonstrated their ability to develop and to adjust themselves to good standards of living, and perhaps even more strikingly, our study of individual members of it, leave us with a distinct impression that there exists in individuals an immense power of growth and adaptation. . . . We would certainly not say that anything could be made of any child—that a favorable environment could produce any kind of development desired, but rather that our study leads us to believe that there are tremendous latent powers within an individual awaiting development, and that under favorable conditions these powers may be developed and directed toward accomplishment.

The Children's Bureau have recently issued *The Promotion of the Welfare and Hygiene of Maternity and Infancy*, a report of the activities undertaken in the administration of the Sheppard-Towner Act from March, 1922, to June, 1923. This affords a very interesting comparison of the methods and accomplishments of the various states in carrying out the act. From the Section on County-Unit Schemes we quote.

The county appears to be the logical unit in state-wide health undertakings. In state plans for maternal and infant hygiene where federal and state funds have been used in matching county funds, the funds have been applied to the furtherance of county public health nursing service. In nearly all of the southern states, where the county health unit plan has been most extensively developed . . . the maternal and infant nursing service has frequently developed as a part of this general health unit plan.

In those states having as an objective the establishment of full-time county health units (usually a full-time health officer, a sanitary inspector, a public health nurse, and a clerical assistant), maternity and infancy work has been considered as a part of the general public health program.

In some states where the establishment of county health units or at least the employment of a county public health nurse is thought to be the ideal way of developing a public health program, the plan has been to provide each county with a nurse paid by the state or jointly by the state and county.

The National Catholic Welfare Conference is publishing a series of pamphlets on health education, the first of which, *Medical Supervision in Catholic Schools*, was noted in our October number.

The second, *Health Through the School—Study in Health Training and Instruction Intended for Elementary Schools*, by Mary G. Spencer, M.A., has just been published.

Part One takes up a Study of Health Instruction, history, need, objectives, principles, teachers responsibilities, motivation, etc., also Age Characteristics, and Interests of Children, Subject Matter of Health Instruction, and Methods in Health Instruction.

Part Two presents a graded outline for the primary, middle and upper grades. A good bibliography is attached.

This is a well planned and valuable pamphlet. It may be obtained from the National Catholic Welfare Conference, 1312 Massachusetts Avenue, Washington, D. C.

The Division of Industrial Hygiene of the New York State Department of Labor has recently issued a *Rapid Reference Manual on Industrial Diseases* prepared by C. T. Graham Rogers, M.D., Medical Inspector of Factories. In addition to The Reporting Law and Extracts from the Workmen's Compensation Law, this little manual contains condensed information on Occupation Diseases, and a tabulated list of some of the diseases and of "the more harmful substances in the indication of the industries in which they are prepared or used, the mode in which they enter the body, and the diseases or symptoms to which they give rise." Treatment is not discussed.

In connection with industrial hazards we call attention also to a pamphlet issued by the United States Department of Labor, *Occupation Hazards and Diagnostic Signs—a Guide to Impairments to be Looked for in Hazardous Occupations*, by Louis T. Dublin and Philip Leiboff. Printed in April, 1922,

but still available from the Government Printing Office, Washington, D. C. Price, 5 cents.

ARNOLD BENNETT AND "TANTRUMS"

"Elsie and the Child," a short story continuation of Arnold Bennett's recent novel, "Riceyman Steps," presents us with a delightful and shrewdly drawn picture of that strange and incalculable personality, a girl child. Elsie, left in the house with the twelve-year-old daughter of her employer,

> had a dim glimpse of the private life of the watched child, as mysterious as the life of birds in the branches, whose enterprising curiosity in some unwatched and unaccounted for moment had led to the astonishing discovery of the key. It was incredible, highly disconcerting.

Later, when the wise, but still merely mortal, mother of Eva made an unfortunate error in judgment, the consequences are thus described:

> The child was now transported into a region where the protests of wise, firm, powerful mothers counted no more than the cheep of a sparrow. She was in a rage of disappointment and anger. Nobody could cast out the devil in her. The devil had the whole room—Eva, Mrs. Raste and Elsie helpless in his domination. Eva stamped her feet; tears rushed from her eyes; she sobbed. Neither of the women dared touch her, lest worse horrors might ensue. Lion tamers with magic subduing spells would not have dared to lay hands on her. She was spiritually as independent, uncontrollable, uninfluenceable in these minutes as anybody ever was in the history of Clerkenwell. And yet what was the exhibition in parents' language but tantrums?

Framingham Monograph No. 10 "Final Summary Report 1917–1923," inclusive, has been published. The foreword says:

> This publication, the last of the Framingham series of monographs, completes the written account of this pioneer effort at health promotion and tuberculosis control on a community wide scale. It does not attempt a detailed presentation of all of the activities of the demonstration. Many of these have been covered in previous publications and reprints. This report aims rather to present a summary of the more important findings, references, being made to the original publications for detail as to method, record forms, statistical tabulations, etc.

The Framingham Community Health and Tuberculosis Demonstration is too well known to need mention here. Also the valuable series of reports which have appeared since the Demonstration Project was made possible by a contribution to the National Tuberculosis Association from the Metropolitan Life Insurance Company.

Everyone interested in any program for community health will want this final report of the series for help and reference.

The New York State Department of Health, Albany, New York, has recently published a pamphlet on *The Public Health Nurse and the Work She Does*, which embodies briefly "the general principles at present governing the nature and scope of the duties and activities of the public health nurse in New York State" and was prepared with the hope that it would serve "as a guide for the necessary and proper steps in the better correlation, coördination and standardization of the work of the public health nurse." An excellent outline which we think would be of interest to nurses in other states.

The Public Health Nursing Section of the Filipino Nurses Association has sent us the first number (Vol. 1, No. 1, October, 1924) of *The Message*, their new publication, printed in Manila, P. I.

This first number contains a "Message" from Pansy V. Besom, Director of Nursing Activities, Philippine Chapter, American Red Cross, and a sketch of the Public Health Nursing Section since its organization in 1923.

We congratulate the officers of the section on their very attractive bulletin. It seems to us remarkable that in such a short time such interest and enthusiasm have been aroused. Our warmest good wishes for the success of the new venture.

The National Health Council has recently prepared a list of public health

magazines in the United States. The list is made up in three divisions—national, state and local. The total number listed is ninety-nine.

Speaking of "health magazines," an interesting meeting of eighteen editors of this group came together in Toronto, called by the Administrative Secretary of the National Health Council.

A second meeting was held at the American Public Health Association Convention in Detroit in October.

School Health Supervision—A Report of the Conference at Detroit, October, 1923 (No. 8, School Health Studies), by Harriet Wedgewood, has just been issued by the Bureau of Education. It contains:

The School Child as a Carrier of Public Health, Dr. Frances Sage Bradley; The Preschool Age and School Entrance, Prof. Arnold Gesell; Training Teachers for Health Work in Rural Schools, Elma Rood; Health Supervision of City School Children, Dr. William DeKleine.

Government Printing Office, Washington, D. C. Price, 5 cents.

PEACE

In the Andes, at the highest point on the frontier, dividing Chile from the Argentine, 13,000 feet above the sea, stands a colossal bronze figure of Christ. The right hand is stretched out in blessing; the left holds a cross. Beneath it is written: "These mountains themselves shall fall and crumble to dust before the people of Chile and the Argentine Republic forget their solemn covenant sworn at the feet of Christ." On the other side is written: "He is our peace who hath made both one."

The figure of Christ was made from bronze obtained when the two nations melted their guns in the general disarmament which followed the successful plea made by a bishop from each country when Chile and the Argentine were on the point of war. The bishop won the support of the peasants and the governments were forced to arbitrate, reduced their armies, sold their warships and gave the money to public works. This is told in a pamphlet written by Professor Gilbert Murray for the League of Nations Union which may be addressed at 15, Grosvenor Crescent, London, S. W. 1.

United States Public Health Service Reports, October 31, 1924, Vol. 39, No. 44, contains an article on *Disabling Illness Among a Group of Industrial Employees.* A number of tables and graphs are included, and a summary, unfortunately too long to quote.

The National Child Labor Committee, 215 Fourth Avenue, New York City, have just published a small pamphlet, *Brass Tacks in the Pending Child Labor Amendment,* in the form of pertinent questions and answers—5 cents a copy.

American Foundation for Social Welfare, Bulletin No. 36.—The Russell Sage Foundation Library has recently issued a bulletin with the above title which should be very valuable to all organizations and individuals interested in keeping in touch with the old and new efforts to crystallize into stable form the desire of men or groups to use their wealth for the common good. This pamphlet presents in bibliographic form information about American Foundations to the date of its publication, June, 1924. It may be obtained from The Russell Sage Foundation, price 30 cents.

The Library Index of periodical literature, published weekly by the National Health Council Library, contains the following classification of subjects: Child Welfare, Delinquency, Health Education, Industrial Hygiene, Mental Hygiene, Nursing, Nutrition, Public Health Nursing, Sex Education, Social Hygiene, Tuberculosis and Venereal Diseases. The index can be obtained from the Library, 370 Seventh Avenue, New York City, for $2.50 a year, postpaid.

NEWS NOTES

Miss Elizabeth F. Miller, President of the Pennsylvania State League of Nursing Education, has been appointed by Dr. Ellen C. Potter, Secretary of Welfare, as the Nursing Consultant of the Pennsylvania Department of Welfare. This is the first appointment of the kind to be made by any state. Miss Miller has had experience in a number of hospitals and has taken post-graduate work at Teachers College.

Miss Miller's services are to be devoted to the development and standardization of nursing service and nurses' and attendants' training schools in the state-owned mental hospitals and the state-owned general hospitals in the anthracite coal field. There will be intimate coöperation between the work of the State Board of Examiners for the Registration of Nurses and the work of the nursing consultant.

In honor of the seventieth birthday of Mrs. Warburg's mother, Mrs. Jacob H. Schiff, Mr. and Mrs. Felix M. Warburg have made a gift of $500,000 to the Henry Street Visiting Nurse Service of New York City. The income from this fund will be sufficient to add seventeen regular nurses to the staff. The additional nurses will enable the Service to take care of about 3,500 more cases this year and will allow at least 30,000 more individual calls to be made by the nurses.

Miss Kate Cowan, graduate of Johns Hopkins Hospital, Baltimore, and of Simmons College, Boston, recently attached to the Department of Public Health Nursing, Toronto University, who has had considerable experience in field work supervision, has been appointed, by the Central Board of the Victorian Order of Nurses for Canada, as supervisor of students for the coming year. This group includes students having their field work with the Victorian Order while taking post-graduate work with the Canadian Universities, Toronto, Western, and McGill.

A health play contest open to junior and senior high schools is planned for the school year, 1924-1925, by the National Tuberculosis Association and its affiliated associations. With this in mind the Association has published an instructive pamphlet, A Health Play Contest, giving all necessary details about the contest and valuable pointers as to play writing, citing such authorities as Professor Baker of Harvard and George M. Cohan. Plays submitted must deal with some aspect of individual community health or hygiene, but may take almost any dramatic form, including that of a musical comedy. English and dramatic classes, it is explained, will probably be depended upon for the actual writing of the play, but physical training and hygiene classes will be interested in the subject matter on health; manual training and drawing groups may help with scenery and "effects," and, indeed, almost every class in the school has an appropriate part outlined. Judges will be David Belasco, Rachel Crothers, Nina Wilcox Putnam, and Dr. Charles J. Hatfield, president of the N.T.A. Plays are to be submitted to *state* tuberculosis and public health associations, not to the National Association, and must be received by April 1.

ANNUAL MEETINGS

Florida

The Florida State Nurses Association met in Pensacola November 18–19. The sessions of the second day were given over to the Public Health Section, with the following program:

Red Cross Work in Florida, Miss Joyce Ely; Maternal and Infant Hygiene Work, Miss N. M. Alvis, State Board of Health, discussion led by Miss Lula M. Davis; School Nursing on a State-Wide Plan, Miss Cora Baertsch, State Board of Health, discussion led by Miss Isabelle MacCann; Industrial Work at Pierce, Mrs. Sayde Burson; Adequate Universal Care of the Sick, Miss Jane Van de Vrede; Public Health Work in a City, Mrs. Lucy Knox McGee, Director Nursing Service, City Board of Health, Jacksonville; American Nursing

Association, Miss Rose M. Ehrenfeld; Program of Activities for Public Health Section, Frances V. Brink, of the N.O.P.H.N. staff.

Papers at other sessions of the meeting included: Practical Phases of the Nursing Profession, Dr. Clarence Hutchinson; Chlorine, Dr. Lischoff.

Among the important matters under discussion were: The national relief fund; loan and scholarship funds; plan for state nursing headquarters; affiliation with State Federation of Women's Clubs; affiliation with State Conference of Social Work.

Officers elected were: President, Mrs. Lucy Knox McGee, Jacksonville; Vice-Presidents, Miss Margaret Green, Pensacola, and Miss Jessie Lynch, Daytona; Secretary, Miss Elizabeth Steil, Jacksonville; Treasurer, Miss Teresa Koten, Jacksonville; Chairman of Public Health Section, Miss Joyce Ely, Perry.

Georgia

The eighteenth annual meeting of the Georgia State Nurses Association was held in Athens November 17–19. The Association voted to raise $1,000 through district groups and to contribute $1,000 from its treasury to start a State nursing headquarters.

The Public Health Nursing Section met on the 19th, Miss Virginia P. Gibbes, Chairman, Presiding. The following program was presented:

The A.C.H.A. Demonstration, Dr. Bernard Carey; address by Miss Marie Phelan of the U. S. Children's Bureau; The Nurse and the Social Worker, Miss Belle Bryson, American Red Cross; The Professional and the Laity, Miss Emma Habenicht, Supervisor of Nursing, Metropolitan Life Insurance Company, Atlanta.

At the open session of the meeting 400 nurses and citizens, including teachers, business men and physicians, were present. Miss Elmira W. Bears, of the N.O.P.H.N. staff, talked on "The Nurse as an Educator."

Following the annual meeting, an Institute for Public Health Nurses was held by the State Association, the Federal Children's Bureau and the State Board of Health, November 20–22. The main subject of discussion was child health nursing, with Miss Phelan of the Children's Bureau in charge of the maternity and infancy discussion and Miss Bears handling the material relating to the school child.

Minnesota

The Minnesota State Branch Organization for Public Health Nursing celebrated its first birthday in a rather prolonged but spirited manner, November 5–8. Besides its own business meeting and two round tables, the State Organization for Public Health Nursing joined in meetings of the State Registered Nurses' Association, State League of Nursing Education, Minnesota Educational Association, and State Sanitary Conference.

Preceding the conference proper, a reception for the three state nursing organizations was held, followed directly by an address from Dr. Lotus D. Coffman, President of the University of Minnesota, and responses from Miss Irene English, President of the State Registered Nurses' Association; Miss Caroline Rankeillour, President of the State League of Nursing Education; and Miss Ruth Houlton, President of the State Organization for Public Health Nursing.

In a joint session with the State Sanitary Conference, the State Organization contributed a dramatic presentation of Communicable Disease Nursing in the Home, given by Miss Judith Wallin, County Public Health Nurse, and Miss Grace Pulley, Minneapolis Visiting Nurse Association. This was followed by a summary of points by Miss Sophie Nelson, St. Louis, and a discussion led by Miss Katherine Dougherty, Superintendent of Nurses, Minneapolis General Hospital, and Miss Hannah Bergren, Supervisor of Contagious Diseases, Minneapolis General Hospital.

The part of the State Organization for Public Health Nursing in its joint program with the Minnesota Educational Association was a talk from Miss Sophie Nelson on "The Nurse's Part in the Community Health Program."

The business meeting of the State Branch was held on Friday afternoon. Reports from the committees on legislation, publicity, membership, and

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supervision showed that each had a definite project and that definite advance had been made with the project chosen by each committee. The committee on education reported a gift of $500 to be used as a nucleus for a loan scholarship fund. Methods for increasing this fund are now being considered. Resolutions were passed in the form of recommendations concerned with standards of preparation for public health nurses, working hours and vacations, length of time required for notice of discontinuing services by the organization and by the public health nurse, uniforms for public health nurses.

The State Organization's round tables came on Saturday morning: First, Round Table on Health Publicity, Hortense Hilbert, Chairman; second, Round Table on Group Teaching, Mildred Smith, Chairman.

The annual meeting of the New Jersey Organization for Public Health Nursing will take place at Atlantic City, January 24, 1925.

A study is to be made of the place of the nurse and nursing service in the dispensary. The work will be under the direction of the Education Committee of the National League of Nursing Education with the coöperation and financial support of the Committee on Dispensary Development of the New York United Hospital Fund. Miss Emilie Robson has been released from the Henry Street Nursing Service to give her entire time to this investigation which is to determine the functions of the nurse in the dispensary, and the best organization of the nursing service from the standpoint of efficiency and also from the standpoint of education.

NEWS FROM THE STATES

Illinois

The Chicago Industrial Nurses Club entertained friends and representatives of industry October 9th. There were fifty-five people present, who listened

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to an instructive and inspiring talk by Mr. Burr, General Auditor of the American Railway Express Company. There was also a musical program.

Below are the aims and purposes of this club:

(1) High qualifications and standards for Industrial Nurses.

(2) An opportunity to discuss our mutual problems.

(3) To encourage interest in all nursing activities and problems through our speakers and reports and discussions of our delegates from State and National Conventions.

(4) Promoting Fellowship among Industrial Nurses.

(5) Fostering an understanding spirit of coöperation with all representatives of Industry.

Massachusetts

The annual election of officers of the Western Massachusetts Industrial Nurses Club, held at their November meeting in Springfield, resulted as follows:

President, Mrs. Ella MacDonald, Farr Alpaca Co., Holyoke; Vice-President, Miss Mary Sheehan, Moore Drop Forge Co., Springfield; Secretary, Miss Helen Greene, American Writing Paper Co., Holyoke; Treasurer, Miss Frances Harper, Wico Electric Co., West Springfield.

Michigan

A scholarship fund has been given to the Detroit Visiting Nurse Association through the kindness of Mrs. Charles B. Davis, a member of the Board. This gift, which was made in memory of a relative, is the first definite scholarship fund the association has had. It will cover a nine months course in public health nursing and a summer session of two months at the University of Michigan. Miss Geneva Hoilien is the recipient of the nine months course. Miss Hoilien, who has had a year with the Detroit Department of Health, a year of industrial nursing and two years with the Association, the last as acting supervisor, will return to her duties with the Association in June, when she will be rated as a regular supervisor.

Miss Milenca Herc, one of the A.C.H.A. scholarship nurses, spent